SOUND HEALTH & WELLNESS TRUST

MEDICAL, PRESCRIPTION DRUG AND VISION OPTIONS

FOR

SOUND PLAN
(over 36 months of employment)

2017 ENROLLMENT

Sound Health & Wellness Trust

Comparison of Medical/Prescription Drug/Vision Benefits Effective January 1, 2017

Sound Plan (over 36 months of employment)

	Sound PPO Plan	Sound Plan Group Health Options (GHO)
Prevention @ 100%	All covered in-network preventive care is paid in full - with no deductibles, coinsurance or co-pays.	
Tier 0 Prescriptions	Tier 0 is the Trust's therapeutically based prescription tier. For the highly cost-effective medications under Tier 0, there is $0 co-pay for participants. Prescriptions under Tier 0 include cholesterol lowering medications (Simvastatin), proton pump inhibitors (Omeprazole – generic of Prilosec OTC, with physician prescription), non-sedating antihistamines (Loratadine - generic of Claritin, with physician prescription), Metformin (for diabetes), and Lancets for diabetes blood testing.	
Annual net deductible (per calendar year)		
▪ Employee Only	$300 for preferred providers $600 for non-preferred providers	$300 for Group Health (In-Network) Providers $600 for Out of Network Providers
▪ Family	$600 for preferred providers $1,800 for non-preferred providers	$600 for Group Health (In-Network) Providers $1,800 for Out of Network Providers
	For family coverage, the deductible applies to the family as a whole.	For family coverage, the deductible applies to the family as a whole.
	Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.	Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your deductible will be higher.
Annual Out of Pocket (OOP) Maximum (per calendar year)		
▪ Employee Only	$2,750 for preferred providers $5,500 for non-preferred providers	$2,750 for Group Health (In-Network) Providers $5,500 for Out of Network Providers
▪ Family	$5,500 for preferred providers $16,500 for non-preferred providers	$5,500 for Group Health (In-Network) Providers $16,500 for Out of Network Providers
Deductible and co-insurance apply to the OOP maximum.	Overall in-network out-of-pocket limit on Essential Health Benefits: $7,150 person / $14,300 family	Overall in-network out-of-pocket limit on Essential Health Benefits: $7,150 person / $14,300 family
	For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family	For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family

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	coverage" maximum is met. Note: If you (and your enrolled spouse) do not update your contact information, take your Personal Health Assessment (PHA), choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.	coverage" maximum is met. Note: If you (and your enrolled spouse) do not update your contact information, take your Health Profile, choose a Primary Care Physician (PCP) and complete health actions during the available time period, your out of pocket will be higher.
Service Area	Covered services are available from any covered provider. However, if you use a Preferred Provider from the Aetna Choice POS ll network for medical services your benefits will be greater. All services provided by non-preferred providers are subject to Usual, Customary and Reasonable (UCR) charges.	When you choose Options In-Network care, you get access to all Group Health Cooperative providers. In addition, you have access to a number of contracted community physicians in the area. If you choose Out of Network care, you can see First Choice Health Network or First Health providers at a discounted rate. Or you can see any licensed provider you want for most covered services. Your out of pocket costs will be higher than if you choose care inside the Options network.

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Benefit percentages apply after deductibles have been met (unless otherwise stated).		
Hospital ▪ Room and Board	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
▪ Ancillary Services	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
▪ Emergency Room (Copay applies only to the Essential Health Benefits OOP maximum)	$100 copay, waived if admitted. In addition, subject to deductible and coinsurance. Copay does not apply to OOP maximum. Life endangering medical emergency at non-preferred hospital covered as if preferred hospital (subject to UCR).	$100 copay at Group Health designated and non-designated facilities, waived if admitted. In addition, subject to In-Network deductible and coinsurance. Copay does not apply to OOP max. Worldwide emergency care is covered.
Ambulance (air/ground)	80%	80%
Surgical Services	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthesia	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Second Surgical Opinion	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Ambulatory Surgical Center	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (inpatient)	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Physician Visits (outpatient, non-preventive services)	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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Diagnostic X-ray and Lab	80% for preferred providers / 60% for non-preferred providers ▪ Chiropractic x-rays limited to one set from one chiropractic visit, per calendar year	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Dental Treatment	80% for preferred providers / 60% for non-preferred providers for treatment for accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident. Routine dental treatment is not covered.	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers for treatment for accidental injuries to natural teeth or fractured jaw if treatment is performed within six months from the date of accident. Routine dental treatment is not covered.
Nursing Services (inpatient and outpatient)	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Blood Transfusion	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Medical Supplies and Equipment	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Prosthetic Devices	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Anesthetic Supplies	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Mental and Nervous Disorder		
▪ Inpatient	80% for preferred providers / 60% for non-preferred providers	80% at Group Health approved facility / 60% for Out of Network facilities
▪ Outpatient	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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Preventive Care: ▪ Physical Exam ▪ Preventive Screenings, Lab Tests ▪ Immunizations and Flu Shots	All preventive services covered in accordance with the Plan's well care schedule: 100% for preferred providers (no deductible) 60% for non-preferred providers (after deductible)	All preventive services covered in accordance with Group Health well care schedule: 100% for Group Health (In-Network) Providers (no deductible) 60% for Out of Network Providers (after deductible)
Chiropractic Care	80% for preferred providers / 60% for non-preferred providers ▪ Benefit limited to $30 per visit ▪ PPO providers provide a discount ▪ Maximum of 20 visits per calendar year (Excess of the $30 per visit applies only to the Essential Health Benefits OOP maximum. Excess of the 20 visits per calendar year does not apply to the OOP maximums.)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 10 self-referral visits for manipulative therapy of the spine and extremities per calendar year; additional visits available when approved by Group Health (In-Network)
Podiatry	80% for preferred providers / 60% for non-preferred providers ▪ Benefit limited to $20 per visit ▪ PPO providers provide a discount ▪ Maximum of 12 visits per calendar year (Excess of the $20 per visit and 12 visits per calendar year applies only to the Essential Health Benefits OOP maximum.)	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Routine foot care not covered, except in the presence of a non-related medical condition affecting the lower limbs
Acupuncture (Non-covered visits 9 through 12 apply only the Essential Health Benefits OOP maximum.)	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of 8 visits per calendar year	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 8 self-referral visits per calendar year; additional visits available when approved by Group Health (In-Network)
Naturopaths	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of 5 visits per calendar year	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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		▪ Maximum of 5 self-referral visits per calendar year; additional visits available when approved by Group Health (In-Network)
Alcoholism and Drug Abuse	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers
Hearing Aid	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of $1,000 in any 3 consecutive calendar years for exam and hearing aid ▪ Rental charges covered for up to 30 days	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers for exams to determine hearing loss ▪ Hearing aids, including hearing aid exams, are covered up to a maximum of $400 per ear, limited to one aid per ear during any 3-year period when authorized by a Group Health physician (In-Network) or with a physician prescription (Out of Network)
Skilled Nursing Facility	80% for preferred providers / 60% for non-preferred providers	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 60 days per calendar year
Home Health Care	100% for preferred providers (no deductible) / 60% for non-preferred providers ▪ Must be in lieu of confinement in hospital or skilled nursing facility	Covered in full (Out of Network subject to UCR) ▪ Must be in lieu of confinement in hospital or skilled nursing facility
Hospice	100% for preferred providers (no deductible) / 60% for non-preferred providers	Covered in full (Out of Network subject to UCR)
Transplant Benefit	80% for preferred providers / 60% for non-preferred providers ▪ Covers only listed procedures	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers

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Rehabilitation		
▪ Outpatient Services	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of 45 visits per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 45 visits per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under
▪ Inpatient Services	80% for preferred providers / 60% for non-preferred providers ▪ Maximum of 30 days per condition per calendar year for physical, occupational, restorative speech, hand and cardiac therapy combined, including services for neurodevelopmentally disabled children age 6 and under	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers ▪ Maximum of 30 days per condition per calendar year for physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under

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If you do not identify yourself or dependents as a member of the Sound Health & Wellness Trust to the pharmacist when your prescription is filled, you will be assessed a processing fee in addition to the co-pay. The processing fee for generic is $10; the processing fee for Brand is $20.		
Retail (30 day supply)	Purchased at a "Trust Network" Pharmacy – copay per 30-day supply:	Copay per 30-day supply (no deductible):
Tier 0: Some highly cost-effective medications ▪ Cholesterol Lowering Medications (Simvastatin) ▪ Proton Pump Inhibitors (Omeprazole – generic of Prilosec OTC, with physician Rx) ▪ Non-sedating Antihistamines (Loratadine - generic of Claritin OTC, with physician RX) ▪ Diabetes products (Metformin and lancets)	$0 copay	$0 copay
Tier 1: Current Generics, some future generics	$6 copay	$6 copay for Generics if on Group Health formulary
Tier 2: Most brand drugs, and more costly or less desirable future generics	$22 copay	$22 copay for Brand if on Group Health formulary
Tier 3: Non-Preferred brand drugs and some undesirable future generics	$35 copay	Not applicable
Brand Name Drug with Generic Available: If you fill a prescription for a brand name drug when there is a generic	Generic copay plus the actual difference in cost between the generic and the brand name drug	Generic copay plus the actual difference in cost between the generic and the brand name drug.

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Maintenance "Mail" at Retail ▪ Tier 3 maintenance drugs	Purchased at certain "Trust Network" pharmacies: $66 for a 90 day supply	Not available
Mail Order ▪ Tier 0 ▪ Tier 1 ▪ Tier 2 ▪ Tier 3 Brand Name Drug with Generic Available	Optional (up to 90 day supply) (copays listed are for a 90 day supply) $0 copay $18 copay $66 copay $70 copay Generic copay plus the actual difference in cost between the generic and the brand name drug	Optional (90 day supply) (copays listed are for a 90 day supply) – no deductible ▪ Must use Group Health Mail Order Program $0 copay $18 copay for Generics if on Group Health formulary $66 copay for Brand if on Group Health formulary Not applicable Generic copay plus the actual difference in cost between the generic and the brand name drug

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Exam	100% at a VSP provider, up to $50 at a non-VSP provider after a $10 copay, once each 12 months from last date of service	80% for Group Health (In-Network) Providers / 60% for Out of Network Providers (no deductible), once each 12 consecutive months
Vision Hardware		
▪ Lenses	100% at a VSP provider, from $50 to $100 at a non-VSP provider; once each 12 months from last date of service	Up to $150 (no deductible); once each 12 consecutive months (Amounts over $150 will apply to the Essential Health Benefits OOP maximum.)
▪ Frames	Up to $95 allowance at a VSP provider, up to $70 at a non-VSP provider; once each 24 months from last date of service	
▪ Contact lenses	Up to $60 copay for contact lens exam (fitting and evaluation) $130 allowance contact lenses at a VSP provider, up to $105 at a non-VSP provider; once each 12 months from last date of service (contacts are in lieu of lenses)	

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FURTHER QUESTIONS?

Sound PPO Plan
206-282-4500 or 800-225-7620
(Choose member, then option 1)

Sound Plan Group Health Options (GHO)
888-901-4636