Live your life

Individual & Family plans
A summary of benefits

Effective: January 1, 2010 - June 30, 2010

GroupHealth®

the doctor you want + the plan you want =

Individual & Family plans that help you do what you want to do.

We all live our lives differently. Some go full speed ahead and some take it nice and easy. But finding health care that fits the way you and your family live is something that's important to us all.

That's why we offer all the choices you need to pick the plan that's right for you. Having one of these in your back pocket means that your care is easy to get and your coverage is there when you need it. It's about letting go of the worry, so you can get on with living your life.

CHOICE

The Balance plans

If choice is first and foremost to you, the Balance plans from Group Health Options, Inc. are great because you can see any doctor you want for primary, specialty, and alternative care. These plans let you choose between the Alliant Plus in-network and out-of-network options, with different levels of coverage.

In-network care includes access to the more than 1,000* Group Health doctors and clinicians who are unavailable with any other health plan provider. In-network care also includes thousands of contracted community providers and the many doctors who practice at Virginia Mason and The Everett Clinic. **Out-of-network care** includes services from any other doctor, anywhere, including discounted rates within the First Choice or Beech Street networks with no balance billing.

Structured like traditional copayment plans, you'll pay a fee for your in- and out-of-network office visits. For some benefits (in- or out-of-network) your coinsurance won't apply until after you pay your deductible. And, your deductible doesn't apply to any preventive care services either in- or out-of-network, or to most in-network office visits, which is a whole lot of value.

*Source: OIC Provider List Form A

The HealthPays® Health Savings Account

This plan qualifies you for a Health Savings Account (HSA), which means you can pair it with a separate bank account designated for pretax money used to pay eligible medical expenses. You choose your own financial institution, so you're sure your money is safely where you want it. There are a few eligibility rules for this plan: You can't be covered under any other plan, enrolled in Medicare, or be eligible as a dependent on another's tax return. However, if you clear these exceptions, and if you want more choice to better manage your health care dollars, this plan puts you in the driver's seat.

Additionally, HealthPays lets you choose between the Alliant Plus in-network and out-of-network options. **In-network care** includes more than 1,000* doctors and providers who practice at Group Health medical centers, thousands of community physicians with whom we contract, and many doctors who practice at Virginia Mason and The Everett Clinic. **Out-of-network care** means you can see any other doctor, anywhere you want, including discounted rates within the First Choice and Beech Street networks with no balance billing.

The Welcome plans

These three plans, offered by Group Health Cooperative, share a unique design. **Your deductible and, in some cases, your coinsurance doesn't kick in until after your fifth outpatient visit.** That means those first five visits are covered with just a copayment or coinsurance, depending on the plan you pick. It's our way of making sure you get the most from your health plan right from the get-go. These plans give you access to the Group Health network of doctors, who practice at more than two dozen medical centers statewide, plus nearly 6,500 contracted providers. Also, you can self-refer to most specialists at Group Health medical centers, which makes getting the care you need as easy as possible.

*Source: OIC Provider List Form A

BALANCE 1000

THE MOST COVERAGE.

The Balance 1000 Plan–'09 is great for those who want total peace-of-mind. Maternity coverage is included, so this is a good plan if you're adding to your family. Your deductible is lower than any other Balance plan, and it doesn't apply to preventive care (in- or out-of-network), or to most in-network office visits. So you get a lot of coverage without first having to meet your deductible.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
BALANCE $1000

	NON-SMOKER	SMOKER
Dependent child under 25*	$129	$129
Adult age 24 or under	$204	$245
25 - 29	$247	$297
30 - 34	$259	$309
35 - 39	$239	$287
40 - 44	$250	$299
45 - 49	$285	$342
50 - 54	$352	$425
55 - 59	$421	$505
60 - 64	$543	$653
65 +	$543	$653

CENTRAL/EASTERN WASHINGTON‡
BALANCE $1000

	NON-SMOKER	SMOKER
Dependent child under 25*	$131	$131
Adult age 24 or under	$209	$251
25 - 29	$253	$304
30 - 34	$264	$316
35 - 39	$245	$294
40 - 44	$255	$306
45 - 49	$291	$350
50 - 54	$361	$434
55 - 59	$431	$517
60 - 64	$556	$667
65 +	$556	$667

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$1,000 per member or $3,000 per family	
MEMBER COINSURANCE	20%	20%
OUT-OF-POCKET LIMIT+ (Deductible does not apply.)	$4,000 per member or $12,000 per family	
BENEFITS	**NO DEDUCTIBLE**	**AFTER DEDUCTIBLE, MEMBER PAYS**
OFFICE VISITS	$30/visit	$30/visit
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	$30/visit	$30/visit
ACUPUNCTURE	$30/visit, up to 8 visits PCY	$30/visit
NATUROPATHY	$30/visit, up to 3 visits PCY	$30/visit
MATERNITY CARE Outpatient prenatal and postpartum visits.	$30/visit	$30/visit
MENTAL HEALTH SERVICES **Outpatient:** Limit total visits PCY to 12 combined for both in- and out-of-network.	$30/visit	$30/visit
LAB/X-RAY SERVICES	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
MATERNITY CARE Delivery & associated hospital care.	20%	20%
MENTAL HEALTH SERVICES **Inpatient:** Limit total days PCY to 12 combined for both in- and out-of-network.	20%	20%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.	20%	20%
EMERGENCY CARE	$100 + 20%	$150 + 20%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	$30/visit	$30/visit $300 individual/$600 family annual benefit maximum
PRESCRIPTION DRUGS **Outpatient:** Drugs and medicines that require prescription, including injectables, contraceptive drugs, devices, and supplies. $3,000 annual maximum combined for in- and out-of-network.	$10 generic/30% brand name 50% non-formulary **Mail order:** $5 discount for 30-day supply	$15 generic/30% brand name 50% non-formulary
VISION CARE $200 hardware benefit per 12 months. Not subject to coinsurance.	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months

\+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.

† PCY = per calendar year

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

* When three or more children are covered, the first two up to age 25 are billed.

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Coverage provided by Group Health Options, Inc.

BALANCE 1500

LOTS OF COVERAGE.

The Balance 1500 Plan–'09 is a comprehensive plan with a lot of coverage. This is a good family plan since maternity care is covered. Your deductible is slightly higher than the Balance 1000 plan, but your premium will be lower. And remember, your deductible doesn't apply to preventive care (in- or out-of-network), or to most in-network office visits, so you get a lot of coverage without your deductible coming into play.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
BALANCE $1500

	NON-SMOKER	SMOKER
Dependent child under 25*	$107	$107
Adult age 24 or under	$173	$207
25 - 29	$209	$251
30 - 34	$218	$261
35 - 39	$202	$242
40 - 44	$211	$253
45 - 49	$241	$289
50 - 54	$298	$357
55 - 59	$355	$427
60 - 64	$459	$550
65 +	$459	$550

CENTRAL/EASTERN WASHINGTON‡
BALANCE $1500

	NON-SMOKER	SMOKER
Dependent child under 25*	$110	$110
Adult age 24 or under	$176	$211
25 - 29	$213	$256
30 - 34	$222	$268
35 - 39	$207	$247
40 - 44	$216	$259
45 - 49	$246	$296
50 - 54	$305	$366
55 - 59	$364	$437
60 - 64	$470	$562
65 +	$470	$562

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$1,500 per member or $4,500 per family	
MEMBER COINSURANCE	30%	30%
OUT-OF-POCKET LIMIT+ (Deductible does not apply.)	$6,000 per member or $18,000 per family	
BENEFITS	**NO DEDUCTIBLE**	**AFTER DEDUCTIBLE, MEMBER PAYS**
OFFICE VISITS	$30/visit	$30/visit
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	$30/visit	$30/visit
ACUPUNCTURE	$30/visit, up to 8 visits PCY	$30/visit
NATUROPATHY	$30/visit, up to 3 visits PCY	$30/visit
MATERNITY CARE Outpatient prenatal and postpartum visits.	$30/visit	$30/visit
MENTAL HEALTH SERVICES **Outpatient:** Limit total visits PCY to 12 combined for both in- and out-of-network.	$30/visit	$30/visit
LAB/X-RAY SERVICES	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
MATERNITY CARE Delivery & associated hospital care.	30%	30%
MENTAL HEALTH SERVICES **Inpatient:** Limit total days PCY to 12 combined for both in- and out-of-network.	30%	30%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.	30%	30%
EMERGENCY CARE	$100 + 30%	$150 + 30%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	$30/visit	$30/visit $300 individual/$600 family annual benefit maximum
PRESCRIPTION DRUGS **Outpatient:** Drugs and medicines that require prescription, including injectables, contraceptive drugs, devices, and supplies. $3,000 annual maximum combined for in- and out-of-network.	$10 generic/30% brand name 50% non-formulary **Mail order:** $5 discount for 30-day supply	$15 generic/30% brand name 50% non-formulary
VISION CARE $200 hardware benefit per 12 months. Not subject to coinsurance.	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months

\+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.
† PCY = per calendar year
‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.
* When three or more children are covered, the first two up to age 25 are billed.

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Coverage provided by Group Health Options, Inc.

BALANCE 2500

COVERAGE WHEN YOU NEED IT.

The Balance 2500 Catastrophic Plan–'09 is for those who need simple catastrophic coverage. If you don't think you'll need maternity care and you don't plan to access care a lot, this might be the plan for you. Like the other Balance plans, you can see any doctor you want. But in-network care comes at a higher coverage level, since your deductible doesn't apply to preventive care (in- or out-of-network), or to most in-network office visits.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
BALANCE $2500

	NON-SMOKER	SMOKER
Dependent child under 25*	$60	$60
Adult age 24 or under	$70	$84
25 - 29	$77	$93
30 - 34	$85	$102
35 - 39	$94	$112
40 - 44	$114	$138
45 - 49	$135	$163
50 - 54	$163	$195
55 - 59	$200	$239
60 - 64	$254	$304
65 +	$254	$304

CENTRAL/EASTERN WASHINGTON‡
BALANCE $2500

	NON-SMOKER	SMOKER
Dependent child under 25*	$62	$62
Adult age 24 or under	$71	$86
25 - 29	$79	$95
30 - 34	$86	$104
35 - 39	$96	$115
40 - 44	$116	$141
45 - 49	$139	$166
50 - 54	$166	$200
55 - 59	$204	$245
60 - 64	$260	$312
65 +	$260	$312

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$2,500 per member or $7,500 per family	
MEMBER COINSURANCE	40%	40%
OUT-OF-POCKET LIMIT+ (Deductible does not apply.)	$8,000 per member or $24,000 per family	
BENEFITS	**NO DEDUCTIBLE**	**AFTER DEDUCTIBLE, MEMBER PAYS**
OFFICE VISITS	$30/visit	$30/visit
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	$30/visit	$30/visit
ACUPUNCTURE	$30/visit, up to 8 visits PCY	$30/visit
NATUROPATHY	$30/visit, up to 3 visits PCY	$30/visit
MATERNITY CARE	Not covered	Not covered
MENTAL HEALTH SERVICES **Outpatient:** Limit total visits PCY to 12 combined for both in- and out-of-network.	$30/visit	$30/visit
LAB/X-RAY SERVICES	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
MENTAL HEALTH SERVICES **Inpatient:** Limit total days PCY to 12 combined for both in- and out-of-network.	40%	40%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	40%	40%
EMERGENCY CARE	$100 + 40%	$150 + 40%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	$30/visit	$30/visit $300 individual/$600 family annual benefit maximum
PRESCRIPTION DRUGS	Not covered	Not covered
VISION CARE Hardware not covered.	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months

\+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.
† PCY = per calendar year
‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.
* When three or more children are covered, the first two up to age 25 are billed.

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Coverage provided by Group Health Options, Inc.

BALANCE 5000

IN CASE OF EMERGENCY.

The Balance 5000 Catastrophic Plan–'09 has the highest deductible of any Balance plan, making it a true catastrophic plan. There's no maternity coverage here, so keep that in mind if you're looking to start a family. Like all the other Balance plans, however, you don't have to pay toward your deductible for preventive care (in- or out-of-network), or for most in-network office visits, so this plan might give you all the coverage you need.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
BALANCE $5000

	NON-SMOKER	SMOKER
Dependent child under 25*	$51	$51
Adult age 24 or under	$59	$70
25 - 29	$64	$77
30 - 34	$70	$85
35 - 39	$78	$94
40 - 44	$95	$114
45 - 49	$112	$135
50 - 54	$135	$163
55 - 59	$167	$200
60 - 64	$211	$254
65 +	$211	$254

CENTRAL/EASTERN WASHINGTON‡
BALANCE $5000

	NON-SMOKER	SMOKER
Dependent child under 25*	$52	$52
Adult age 24 or under	$60	$71
25 - 29	$66	$79
30 - 34	$72	$86
35 - 39	$80	$96
40 - 44	$97	$116
45 - 49	$114	$139
50 - 54	$139	$166
55 - 59	$171	$204
60 - 64	$217	$260
65 +	$217	$260

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$5,000 per member or $15,000 per family	
MEMBER COINSURANCE	50%	50%
OUT-OF-POCKET LIMIT+ (Deductible does not apply.)	$10,000 per member or $30,000 per family	
BENEFITS	**NO DEDUCTIBLE**	**AFTER DEDUCTIBLE, MEMBER PAYS**
OFFICE VISITS	$30/visit	$30/visit
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	$30/visit	$30/visit
ACUPUNCTURE	$30/visit, up to 8 visits PCY	$30/visit
NATUROPATHY	$30/visit, up to 3 visits PCY	$30/visit
MATERNITY CARE	Not covered	Not covered
MENTAL HEALTH SERVICES **Outpatient:** Limit total visits PCY to 12 combined for both in- and out-of-network.	$30/visit	$30/visit
LAB/X-RAY SERVICES	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
MENTAL HEALTH SERVICES **Inpatient:** Limit total days PCY to 12 combined for both in- and out-of-network.	50%	50%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	50%	50%
EMERGENCY CARE	$100 + 50%	$150 + 50%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	$30/visit	$30/visit $300 individual/$600 family annual benefit maximum
PRESCRIPTION DRUGS	Not covered	Not covered
VISION CARE Hardware not covered.	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months

\+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.
† PCY = per calendar year
‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.
* When three or more children are covered, the first two up to age 25 are billed.

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Coverage provided by Group Health Options, Inc.

WELCOME 500

THE MOST COVERAGE.

The Welcome 500 Plan–'09 offers the most coverage of any of the Welcome plans. Your first five visits are covered with a simple $30 copayment. You won't need to start paying toward your $500 deductible until you've exhausted those five visits. This might be the plan for you if you want a level of cost predictability every time you go to the doctor.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
WELCOME $500

	NON-SMOKER	SMOKER
Dependent child under 25*	$149	$149
Adult age 24 or under	$236	$284
25 - 29	$256	$308
30 - 34	$297	$357
35 - 39	$278	$333
40 - 44	$290	$348
45 - 49	$331	$398
50 - 54	$410	$492
55 - 59	$489	$586
60 - 64	$631	$757
65 +	$631	$757

CENTRAL/EASTERN WASHINGTON‡
WELCOME $500

	NON-SMOKER	SMOKER
Dependent child under 25*	$152	$152
Adult age 24 or under	$242	$290
25 - 29	$282	$339
30 - 34	$306	$367
35 - 39	$284	$340
40 - 44	$297	$356
45 - 49	$339	$407
50 - 54	$420	$504
55 - 59	$500	$600
60 - 64	$646	$775
65 +	$646	$775

	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$500 per member or $1,500 per family
MEMBER COINSURANCE	20%
OUT-OF-POCKET LIMIT** (Deductible does not apply.)	$4,000 per member or $12,000 per family
BENEFITS	**AFTER DEDUCTIBLE, MEMBER PAYS**
	First 5 visits: You pay only your copayment. Your deductible and coinsurance do not apply until **after** the 5th visit for services indicated by ■
OFFICE VISITS Includes urgent care.	■ $30 + 20%
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	■ $30 + 20%
MANIPULATIVE THERAPY	■ $30 + 20%, up to 10 visits PCY†
ACUPUNCTURE	■ $30 + 20%, up to 8 visits PCY
NATUROPATHY	■ $30 + 20%, up to 3 visits PCY
MATERNITY CARE Outpatient prenatal and postpartum visits. Delivery & associated hospital care.	■ $30 + 20% $500 per day to 5 days/admit + 20%
MENTAL HEALTH SERVICES – INPATIENT	$500 per day to 5 days/admit + 20% coinsurance Up to 12 days PCY
MENTAL HEALTH SERVICES – OUTPATIENT	■ $30 + 20%, up to 12 visits PCY
LAB/X-RAY SERVICES	First $500 PCY covered in full Then 20% and deductible apply
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.	$500 per day to 5 days/admit + 20% coinsurance
PRESCRIPTION DRUGS – OUTPATIENT Drugs and medicines that require prescription, including injectables, contraceptive drugs, devices, and supplies.	$20 copay generic/$40 copay brand name $3,000 annual benefit maximum Not subject to deductible **Mail order:** $5 discount for 30-day supply
EMERGENCY CARE Group Health or Group Health–designated facilities. Non-Group Health or non-Group Health–designated facilities worldwide.	$100 + 20% $150 + 20%
VISION CARE	■ $30 + 20% for routine eye exam and $200 hardware benefit per 12 month period. Hardware not subject to deductible or coinsurance.

* When three or more children are covered, the first two up to age 25 are billed.

** Member coinsurance applies.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

† PCY = per calendar year

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Coverage provided by Group Health Cooperative.

WELCOME 1750

A HAPPY MEDIUM.

The Welcome 1750 Catastrophic Plan–'09 is a nice compromise between the other two Welcome plans. You'll pay 40% coinsurance for your first five visits, and you don't have to start paying toward the $1,820 deductible until your sixth. This plan might be for you if you want more than simple catastrophic coverage, and you don't think you'll need a lot of care.

NOTE: Deductible increases to $1,820 effective January 1, 2010 per Washington State law.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
WELCOME $1750

	NON-SMOKER	SMOKER
Dependent child under 25*	$71	$71
Adult age 24 or under	$84	$99
25 - 29	$92	$110
30 - 34	$101	$121
35 - 39	$111	$133
40 - 44	$136	$162
45 - 49	$159	$191
50 - 54	$192	$231
55 - 59	$236	$285
60 - 64	$302	$361
65 +	$302	$361

CENTRAL/EASTERN WASHINGTON‡
WELCOME $1750

	NON-SMOKER	SMOKER
Dependent child under 25*	$73	$73
Adult age 24 or under	$85	$102
25 - 29	$94	$112
30 - 34	$103	$123
35 - 39	$113	$137
40 - 44	$138	$166
45 - 49	$163	$195
50 - 54	$197	$235
55 - 59	$242	$291
60 - 64	$308	$369
65 +	$308	$369

	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$1,820 per member or $5,250 per family
MEMBER COINSURANCE	40%
OUT-OF-POCKET LIMIT** (Deductible does not apply.)	$6,000 per member or $18,000 per family
BENEFITS	**AFTER DEDUCTIBLE, MEMBER PAYS**
	First 5 visits: You pay 40% coinsurance. Your deductible does not apply until **after** the 5th visit for services indicated by ■
OFFICE VISITS Includes urgent care.	■ 40%
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	■ 40%
MANIPULATIVE THERAPY	■ 40%, up to 10 visits PCY†
ACUPUNCTURE	■ 40%, up to 8 visits PCY
NATUROPATHY	■ 40%, up to 3 visits PCY
MATERNITY CARE	Not covered
MENTAL HEALTH SERVICES – INPATIENT	40%, up to 12 days PCY
MENTAL HEALTH SERVICES – OUTPATIENT	■ 40%, up to 12 visits PCY
LAB/X-RAY SERVICES	40%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	40%
PRESCRIPTION DRUGS	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities. Non-Group Health or non-Group Health–designated facilities worldwide.	$100 + 40% $150 + 40%
VISION CARE	■ 40% for routine eye exam and $200 hardware benefit per 12 month period. Hardware not subject to deductible or coinsurance.

* When three or more children are covered, the first two up to age 25 are billed.

** Member coinsurance applies.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

† PCY = per calendar year

NOTE: This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other terms and conditions apply. Lifetime benefit maximum of $2 million applies to all plans. All plans cover on-the-job-injury-related health care costs for partners, proprietors, or corporate officers who are not covered by a workers' compensation act, subject to the plan's cost shares and benefit limitations.

Coverage provided by Group Health Cooperative.

WELCOME 3500

IN CASE OF EMERGENCY.

The Welcome 3500 Catastrophic Plan–'09 is the plan to get if you only need catastrophic coverage. Your first five outpatient visits are covered at 50% coinsurance, and you don't need to begin paying toward your $3,500 deductible until after that. If you don't anticipate seeing a doctor very often, this might be the plan for you.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
WELCOME $3500

	NON-SMOKER	SMOKER
Dependent child under 25*	$59	$59
Adult age 24 or under	$69	$82
25 - 29	$76	$90
30 - 34	$82	$99
35 - 39	$92	$110
40 - 44	$112	$134
45 - 49	$132	$159
50 - 54	$159	$191
55 - 59	$196	$235
60 - 64	$248	$298
65 +	$248	$298

CENTRAL/EASTERN WASHINGTON‡
WELCOME $3500

	NON-SMOKER	SMOKER
Dependent child under 25*	$60	$60
Adult age 24 or under	$70	$84
25 - 29	$77	$93
30 - 34	$85	$102
35 - 39	$94	$112
40 - 44	$114	$138
45 - 49	$135	$163
50 - 54	$163	$195
55 - 59	$201	$241
60 - 64	$254	$305
65 +	$254	$305

	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$3,500 per member or $10,500 per family
MEMBER COINSURANCE	50%
OUT-OF-POCKET LIMIT** (Deductible does not apply.)	$10,000 per member or $30,000 per family
BENEFITS	**AFTER DEDUCTIBLE, MEMBER PAYS**
	First 5 visits: You pay 50% coinsurance. Your deductible does not apply until **after** the 5th visit for services indicated by ■
OFFICE VISITS Includes urgent care.	■ 50%
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	■ 50%
MANIPULATIVE THERAPY	■ 50%, up to 10 visits PCY†
ACUPUNCTURE	■ 50%, up to 8 visits PCY
NATUROPATHY	■ 50%, up to 3 visits PCY
MATERNITY CARE	Not covered
MENTAL HEALTH SERVICES – INPATIENT	50%, up to 12 days PCY
MENTAL HEALTH SERVICES – OUTPATIENT	■ 50%, up to 12 visits PCY
LAB/X-RAY SERVICES	50%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	50%
PRESCRIPTION DRUGS	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities. Non-Group Health or non-Group Health–designated facilities worldwide.	$100 + 50% $150 + 50%
VISION CARE	■ 50% for routine eye exam and $200 hardware benefit per 12 month period. Hardware not subject to deductible or coinsurance.

* When three or more children are covered, the first two up to age 25 are billed.

** Member coinsurance applies.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

† PCY = per calendar year

NOTE: This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other terms and conditions apply. Lifetime benefit maximum of $2 million applies to all plans. All plans cover on-the-job-injury-related health care costs for partners, proprietors, or corporate officers who are not covered by a workers' compensation act, subject to the plan's cost shares and benefit limitations.

Coverage provided by Group Health Cooperative.

HEALTHPAYS HSA

CONTROL YOUR MONEY.

HealthPays® Health Savings Account 2000 Individual/4000 Family Catastrophic Plan–'09 is a qualified, high-deductible health plan that lets you set up a bank account so you can sock away pretax money to use for your health care expenses. You don't need to pay toward your deductible for any preventive care, no matter whether you get care in- or out-of-network. Notice that the coinsurance is slightly lower if you opt for in-network care.

Rates effective January 1, 2010–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON‡
HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	$58	$58
Adult age 24 or under	$67	$80
25 - 29	$73	$88
30 - 34	$80	$97
35 - 39	$89	$107
40 - 44	$108	$131
45 - 49	$129	$155
50 - 54	$155	$186
55 - 59	$191	$229
60 - 64	$242	$290
65 +	$242	$290

CENTRAL/EASTERN WASHINGTON‡
HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	$59	$59
Adult age 24 or under	$68	$82
25 - 29	$76	$90
30 - 34	$82	$99
35 - 39	$92	$110
40 - 44	$111	$134
45 - 49	$132	$158
50 - 54	$159	$190
55 - 59	$195	$234
60 - 64	$247	$297
65 +	$247	$297

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$2,000 per member or $4,000 per family	
MEMBER COINSURANCE	10%	20%
OUT-OF-POCKET LIMIT+ (Deductible included)	$5,100 per member or $10,200 per family	
BENEFITS	**AFTER DEDUCTIBLE, MEMBER PAYS**	
OFFICE VISITS	10%	20%
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	10%	20%
ACUPUNCTURE	10%, up to 8 visits PCY	20%
NATUROPATHY	10%, up to 3 visits PCY	20%
MATERNITY CARE	Not covered	Not covered
MENTAL HEALTH SERVICES **Inpatient:** Limit total days PCY to 12 combined for both in- and out-of-network.	10%	20%
MENTAL HEALTH SERVICES **Outpatient:** Limit total visits PCY to 12 combined for both in- and out-of-network.	10%	20%
LAB/X-RAY SERVICES	10%	20%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	10%	20%
PRESCRIPTION DRUGS	Not covered	Not covered
EMERGENCY CARE	10%	10%
VISION CARE	Not covered	Not covered
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.	10%	20% $300 individual/$600 family annual benefit maximum

\+ Member coinsurance and annual deductible apply to out-of-pocket limit.

† PCY = per calendar year

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

* When three or more children are covered, the first two up to age 25 are billed.

NOTE: Family = individual plus one more. The family deductible must be met before any benefits are covered, except for preventive care.

NOTE: Children under 18 can not enroll as primary subscriber.

NOTE: This is a summary of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the master policy or agreements. Other terms and conditions apply. Lifetime benefit maximum of $2 million applies to all plans. All plans cover on-the-job-injury-related health care costs for partners, proprietors, or corporate officers who are not covered by a workers' compensation act, subject to the plan's cost shares and benefit limitations.

Coverage provided by Group Health Options, Inc.

Individual & Family plan

DENTAL

2009 PLAN YEAR #1126 AND #00585 SUMMARY OF BENEFITS

Group Health's* Individual & Family plan members are eligible to enroll in the Washington Dental Service (WDS) PPO or Premier Network program with slightly better benefits if you see a PPO provider. This WDS dental plan gives you the freedom to use any dentist. Check with your dentist to see if they are part of the PPO or Premier Network. The plan will pay a maximum of $1,000 in covered benefits for each person in any calendar year. **Other benefits, limitations, and exclusions apply to this plan. This is a brief summary of coverage, not a contract.**

If you seek treatment from a WDS dentist, your dentist will submit claim forms, and WDS's payment will be made directly to your dentist based on the dentist's pre-approved fees. You are only responsible for ensuring that your dentist completes and mails claim forms to WDS. More than 90 percent of the dentists in Washington state are WDS participants.

If you receive treatment from a dentist who is not a participant of WDS, you will be responsible for submitting the claim form. Payment will be based on actual charges or maximum allowable fees for non participating dentists, whichever is less. If you have any questions, please call WDS Customer Service at **1-800-554-1907,** or visit **www.DeltaDentalWA.com.**

Following is a list of your covered services according to type of service and your cost share. **Note:** Your plan includes the services in Class I, Class II, and Class III listed below.

Class I: You are covered at 100% with no deductible.
Preventive and diagnostic care:

- Routine exams and cleanings (twice in a benefit period)
- Fluoride treatment for adults and children (twice in a benefit period)
- Sealants (once per tooth every two years)
- Dental X-rays

Class II: You are covered at 50% with a $50 per person per calendar year deductible if you see a Premier or non-Member dentist† or no deductible if you see a PPO dentist.
Basic dental expenses:

- Fillings
- Oral surgery
- Endodontics (i.e., root canal therapy)
- Periodontics

Class III: You are covered at 30% with a $50 per person per calendar year deductible if you see a Premier or non-Member dentist† or no deductible if you see a PPO dentist.
Major expenses:

- Crowns, implants, and onlays
- Dentures, bridges, and partials
- Repair and adjustment to prosthetic devices
- Nightguards—under certain conditions of oral health (must be approved)

†$150 per family calendar year deductible maximum

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.
+Children under 3 are not required to enroll.

DELTA DENTAL®
Washington Dental Service

MONTHLY RATES

Subscriber	$47.84
Subscriber and child(ren)+	$84.45
Subscriber and spouse	$90.31
Subscriber and family+	$126.91

GENERAL EXCLUSIONS

- Dentistry for cosmetic reasons.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion, and restorations for malalignment of teeth.
- Application of desensitizing agents.
- Experimental services or supplies.
- General anesthesia/intravenous (deep) sedation, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures.
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections, or prescriptions drugs.
- In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
- Broken appointments
- Patient management problems
- Completing insurance forms
- Habit-breaking appliances or orthodontic services or supplies.
- TMJ services or supplies
- WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- All other services not specifically included in the Contract as Covered Dental Benefits.

Individual & Family plan

TERMS AND CONDITIONS

HERE'S THE STUFF YOU NEED TO KNOW SO THERE ARE NO SURPRISES DOWN THE ROAD.

1. **Acceptance of application:** Group Health's* acceptance of you and your dependents for coverage is based upon the score determined by the Washington State Health Insurance Pool (WSHIP) Standard Health Questionnaire(s) unless exempt by the questionnaire's requirements unless an exemption under the law applies. In order to process your application, Group Health must receive the Individual & Family plan application signed by you and your spouse/domestic partner, the signed questionnaire(s) for each family member to be enrolled, and a Certificate of Creditable Coverage (if available).
2. **Adults applying as a Guarantor (adults aged 18 or older, seeking coverage for dependents only):** As a Guarantor, you hereby agree to accept the financial and contractual responsibilities of all dependents listed on the application. A Financial Guarantor may enroll only dependent children under the age of 18, or a dependent who is totally incapable of self-sustaining employment as noted in #3 below. The oldest/only child (noted as Applicant/Subscriber on the application) is charged the lowest adult age rate, while the next two dependent children are each charged the child rate. There is no charge for any additional dependent children.
3. **Dependent children:** Except as noted in #2 above, when enrolling three or more children, only the first two will be billed up to the age of 25. Dependents may be covered to the age of 25. An eligible dependent child who is totally incapable of self-sustaining employment because of a developmental or physical disability, and is chiefly dependent upon the Contract Holder for support and maintenance, may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of such a disability will be required at the time of application and periodically once enrolled.
4. **Coverage effective date:** The effective date of your application is based upon Group Health's receipt of your completed application documents as noted in #1 above. All application documents must be received in Group Health's Seattle Sales Department.
    - For application documents received on or before the 20th of the month, medical coverage will begin on the first day of the following month. (Example: If your application is received on or before Oct. 20, then enrollment is effective Nov. 1.)
    - For application documents received on the 21st through the end of the month, medical coverage will begin on the first of the month following the first full month after receipt. (Example: If your application is received Oct. 21–31, then your coverage begins Dec. 1.)
5. **Premium payments:** Premium payments are payable on a calendar month basis on or before the first day of the month, subject to a grace period of 10 days. Payment can be set up through monthly billing, paid by check or money order, or as monthly automatic withdrawal from a checking or savings account. Premium payments are subject to change by Group Health's Board of Trustees, and a 30-day written notice of these changes will be sent to the Contract Holder's residential address unless there is a billing address on your application.
6. **Revoking coverage:** Failure to answer questions fully and correctly on your application documents may result in Group Health's refusal to extend coverage, cancellation of coverage, or revocation of coverage for you and/or your family members.
7. **Applicant's financial liability:** a) If any hospital or medical service is rendered to you and/or your dependent(s) prior to your effective date of coverage, you will be responsible for paying for those services. These noncovered services will be billed to you at full schedule rates. Regardless of whether you and/or your dependents become a member, you will be responsible for payment of such charges; b) Prior Authorizations: Upon termination from the Individual & Family plan, any outstanding prior authorizations for health care for the terminated individual(s) will no longer be valid, and you will be financially liable for any additional services obtained.
8. **Pre-existing conditions:** These plans contain a nine-month pre-existing condition clause that excludes coverage for any condition for which there has been diagnosis, treatment (including prescribed drugs), or medical advice within the six-month period prior to the effective date of coverage, or for a condition for which symptoms existed within the six-month period prior to the date of coverage for which a prudent person would have sought advice or treatment within the six months prior to the effective date of coverage. Section 6 of the Individual & Family plan application will help us determine whether you have Creditable Coverage, which would allow Group Health to waive pre-existing conditions/exclusions for you and/or your dependent(s).
9. **Portability (Creditable Coverage):** If you have been covered within the last 63 days by a plan with equivalent or greater overall benefits than the plan you purchase, we will waive pre-existing conditions or credit that coverage. If you had a 64-day-or-more break in coverage, no portability credit will be applied for pre-existing conditions.
10. **Washington state residency & counties served:** You must be a permanent resident of Washington state and reside in one of the counties in our service area in order to qualify for coverage from the Group Health Individual & Family plan. The counties that are served by the Individual & Family plan are:
    - Central/Eastern Washington: Benton, Columbia, Franklin, Kittitas, Walla Walla, Yakima, Spokane, and Whitman
    - Western Washington: Grays Harbor (ZIP codes 98541, 98557, 98559, and 98568), Island, King, Kitsap, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Thurston, and Whatcom
11. **Changing plans:** Once you enroll in a Group Health Individual & Family plan, you have the option to transition to any of our other open plans. When making any plan changes, you may be required to go through health screening again, so do not cancel your current coverage until you have been notified of your eligibility for enrollment into the plan for which you are applying. **Note:** If you are changing from an Individual & Family Group Health Cooperative plan to an Individual & Family Group Health Options, Inc. plan, or vice-versa, you and your dependents will be required to complete a new Standard Health Questionnaire.
12. **Adding dependents:** Subject to your plan's terms, you may add eligible dependents to your plan at a later date. Health screening may be required for these dependents prior to their enrollment, so please review the Standard Health Questionnaire of Washington State to determine whether or not the eligible dependents meet one of the exceptions.
13. **Health screen exemptions (exceptions):** Health screening may not pertain to you when you apply for enrollment or when you want to transition from one plan to another. Check the Application under Section 7, or the Standard Health Questionnaire of Washington State, to see if one of the exemptions applies to you or your dependents.

* Coverage provided by Group Health Cooperative or Group Health Options, Inc.

Individual & Family plan

EXCLUSIONS AND LIMITATIONS

YES, HERE'S MORE FINE PRINT. BUT PLEASE GIVE IT A READ. IT'S IMPORTANT STUFF.

The Individual & Family plans for Group Health* have general exclusions and limitations as shown below. Any treatment or service for these conditions becomes your responsibility and you will be required to pay in full. Unless otherwise noted in our Medical Coverage Agreements, these plans have a nine-month waiting period for pre-existing conditions. If you've had prior coverage and Group Health receives your application for coverage within 63 days of that coverage, you may be eligible for portability on pre-existing conditions once we review your Certificate of Creditable Coverage.

- Chemical dependency (limited)
- Cosmetic services (limited)
- Dental services
- Experimental/investigational services
- Eyeglasses/contact lenses (specific plans)
- Hearing aids and related examinations
- Infertility
- Learning disorders
- Maternity (specific plans, as noted in Medical Coverage Agreement)
- Obesity/morbid obesity
- Orthognathic surgery
- Orthotics, except for treatment for diabetics (limited)
- Over-the-counter/nonprescription drugs
- Prescriptions (specific plans)
- Routine foot care (limited)
- Services or supplies not specifically listed as covered in the Medical Coverage Agreement
- Sexual dysfunction
- Sterilization reversal
- Temporomandibular joint disorder (TMJ) (limited)

You may seek treatment for any of the conditions listed as excluded or limited in the Medical Coverage Agreement (your contract with Group Health). However, you will be responsible for the cost of services not covered by this contract. This information is not a contract, nor does it cover all exclusions or limitations. Once you become a member you will receive a copy of your Medical Coverage Agreement, which will outline your coverage in detail. If you would like to see a sample copy of the Medical Coverage Agreement prior to applying for this coverage, please talk to our Group Health Individual & Family Plan sales staff, or your broker/agent.

* Coverage provided by Group Health Cooperative or Group Health Options, Inc.

GLOSSARY

WHAT'S WHAT?

If a lot of this seems like Greek to you, we understand. That's why we've defined some of the most common terms here. Understanding these common terms will help as you look through this summary.

Coinsurance | This is the percentage of the cost of the care you receive. You'll notice that the coinsurance levels differ among all of the plans.

Copayment | This is a fixed-fee that you pay when you get care in person. Keep in mind, not all plans require a copayment.

Deductible | This is what you'll pay before your full coverage kicks in. Every plan has a deductible, but in many cases the deductible does not apply to certain services.

In-network | This is care you receive from the more than 1,000 providers at more than two dozen Group Health medical centers, or from thousands of contracted community providers. And, for the Balance and HealthPays plans, the in-network option includes all the doctors who practice with Virginia Mason and The Everett Clinic.

Inpatient care | This is care you get in person that requires you to stay overnight in a hospital. It could be for a physical or mental ailment.

Medicare | Benefits provided by the Federal government for individuals over the age of 65, individuals under 65 who have been on disability for 24 consecutive months, or any individual with ESRD (end stage renal disease).

Out-of-network | This includes all doctors who do not work for Group Health or who are not contracted with Group Health to provide in-network care. For the Balance and HealthPays plans, this means you can see any doctor you want, anywhere. Your coverage level will be slightly less than if you receive care in-network. The Welcome plans do not have an out-of-network option.

Out-of-pocket limit | This is the maximum you'd ever have to pay for covered services in a calendar year. Notice that each plan has different levels for individuals and for families. Your coinsurance applies to your out-of-pocket limit, but your deductible and copayments (if applicable to your plan) do not, except on the HSA plan.

Outpatient care | This is care you get in person that doesn't require you to stay in a hospital. It could be a visit to see your personal physician, an acupuncturist, or even a specialist.

GroupHealth

www.ghc.org
1-800-358-8815

Remember, this is just a summary, so if you need more information or just another definition, give I&F Sales a call. Our representatives are ready to answer your questions.

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