Plans for individuals and families

SUMMARY OF BENEFITS

EFFECTIVE: JULY 1, 2010 – JUNE 30, 2011

GroupHealth
Well beyond medicine℠

the doctor you want + the plan you want =

Individual and 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 in the U.S., 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 preventive care office visits, and 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 from Group Health Options, Inc., 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 in the U.S., 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 1250

THE MOST COVERAGE.

The Balance 1250 Plan–'10 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 office visits, and to most in-network office visits. So you get a lot of coverage without first having to meet your deductible.

Rates effective July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
BALANCE $1250

	NON-SMOKER	SMOKER
Dependent child under 25*	$146	$146
Adult age 24 or under	$231	$277
25–29	$280	$336
30–34	$293	$350
35–39	$271	$325
40–44	$283	$339
45–49	$323	$387
50–54	$399	$481
55–59	$477	$572
60–64	$615	$739
65 +	$615	$739

CENTRAL/EASTERN WASHINGTON‡
BALANCE $1250

	NON-SMOKER	SMOKER
Dependent child under 25*	$148	$148
Adult age 24 or under	$237	$284
25–29	$286	$344
30–34	$299	$358
35–39	$277	$333
40–44	$289	$346
45–49	$329	$396
50–54	$409	$491
55–59	$488	$585
60–64	$629	$755
65 +	$629	$755

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$1,250 per member or $3,750 per family	
MEMBER COINSURANCE	20%	20%
OUT-OF-POCKET LIMIT+ Deductible does not apply.	$5,000 per member or $15,000 per family	
BENEFITS	**NO DEDUCTIBLE**	**AFTER DEDUCTIBLE, MEMBER PAYS**
OFFICE VISITS Including mental health outpatient services.	$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 non-routine prenatal and postpartum visits. Copay waived for routine care.	$30/visit	$30/visit
	AFTER DEDUCTIBLE, MEMBER PAYS	
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Includes mental health inpatient treatment and maternity care (delivery and associated hospital care).	$200 per day up to 5 days/admit + 20%	$200 per day up to 5 days/admit + 20%
LAB/X-RAY SERVICES	Deductible waived on first $500 PCY, then deductible and 20% apply.	20%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)	
EMERGENCY CARE	$100 + 20%	$150 + 20%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS 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 self-administered 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, 98559, & 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 1750

LOTS OF COVERAGE.

The Balance 1750 Plan–'10 is a 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 1250 plan, but your premium will be lower. And remember, your deductible doesn't apply to preventive care office visits, and to most in-network office visits, so you get a lot of coverage without your deductible coming into play.

Rates effective July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
BALANCE $1750

	NON-SMOKER	SMOKER
Dependent child under 25*	$122	$122
Adult age 24 or under	$196	$235
25–29	$237	$285
30–34	$248	$296
35–39	$229	$275
40–44	$240	$287
45–49	$274	$328
50–54	$338	$405
55–59	$403	$485
60–64	$521	$625
65 +	$521	$625

CENTRAL/EASTERN WASHINGTON‡
BALANCE $1750

	NON-SMOKER	SMOKER
Dependent child under 25*	$125	$125
Adult age 24 or under	$200	$240
25–29	$242	$291
30–34	$252	$304
35–39	$235	$281
40–44	$245	$294
45–49	$279	$336
50–54	$346	$416
55–59	$413	$496
60–64	$534	$638
65 +	$534	$638

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$1,750 per member or $5,250 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 Including mental health outpatient services.	$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 non-routine prenatal and postpartum visits. Copay waived for routine care.	$30/visit	$30/visit
	AFTER DEDUCTIBLE, MEMBER PAYS	
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Includes mental health inpatient treatment and maternity care (delivery and associated hospital care).	$200 per day up to 5 days/admit + 30%	$200 per day up to 5 days/admit + 30%
LAB/X-RAY SERVICES	Deductible waived on first $500 PCY, then deductible and 30% apply.	30%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)	
EMERGENCY CARE	$100 + 30%	$150 + 30%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS 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 self-administered 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, 98559, & 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–'10 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 office visits, and to most in-network office visits.

Rates effective July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
BALANCE $2500

	NON-SMOKER	SMOKER
Dependent child under 25*	$69	$69
Adult age 24 or under	$80	$97
25–29	$88	$107
30–34	$98	$117
35–39	$108	$129
40–44	$131	$159
45–49	$155	$187
50–54	$187	$224
55–59	$230	$275
60–64	$292	$349
65 +	$292	$349

CENTRAL/EASTERN WASHINGTON‡
BALANCE $2500

	NON-SMOKER	SMOKER
Dependent child under 25*	$71	$71
Adult age 24 or under	$82	$99
25–29	$91	$109
30–34	$99	$120
35–39	$110	$132
40–44	$133	$162
45–49	$160	$191
50–54	$191	$230
55–59	$234	$282
60–64	$299	$359
65 +	$299	$359

	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 Including mental health outpatient services.	$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
	AFTER DEDUCTIBLE, MEMBER PAYS	
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugswhile in hospital. Includes mental health inpatient treatment.	$100 per day up to 5 days/admit + 40%	$100 per day up to 5 days/admit + 40%
LAB/X-RAY SERVICES	Deductible waived on first $500 PCY, then deductible and 40% and deductible apply.	40%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)	
EMERGENCY CARE	$100 + 40%	$150 + 40%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS 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, 98559, & 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–'10 has the highest deductible of any Balance 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 office visits, and for most in-network office visits, so this plan might give you all the coverage you need.

Rates effective July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
BALANCE $5000

	NON-SMOKER	SMOKER
Dependent child under 25*	$57	$57
Adult age 24 or under	$67	$79
25–29	$72	$87
30–34	$79	$96
35–39	$88	$106
40–44	$107	$129
45–49	$126	$152
50–54	$152	$184
55–59	$188	$225
60–64	$238	$286
65 +	$238	$286

CENTRAL/EASTERN WASHINGTON‡
BALANCE $5000

	NON-SMOKER	SMOKER
Dependent child under 25*	$59	$59
Adult age 24 or under	$68	$80
25–29	$74	$89
30–34	$81	$97
35–39	$90	$108
40–44	$109	$131
45–49	$129	$157
50–54	$157	$187
55–59	$193	$230
60–64	$245	$293
65 +	$245	$293

	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 Including mental health outpatient services.	$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
	AFTER DEDUCTIBLE, MEMBER PAYS	
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Includes mental health inpatient treatment.	$100 per day up to 5 days/admit + 50%	$100 per day up to 5 days/admit + 50%
LAB/X-RAY SERVICES	Deductible waived on first $500 PCY, then deductible and 50% apply.	50%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)	
EMERGENCY CARE	$100 + 50%	$150 + 50%
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS 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, 98559, & 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 750

THE MOST COVERAGE.

The Welcome 750 Plan–'10 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 $750 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 July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
WELCOME $750

	NON-SMOKER	SMOKER
Dependent child under 25*	$156	$156
Adult age 24 or under	$246	$297
25–29	$267	$322
30–34	$310	$373
35–39	$290	$348
40–44	$303	$363
45–49	$346	$416
50–54	$428	$514
55–59	$511	$612
60–64	$659	$790
65 +	$659	$790

CENTRAL/EASTERN WASHINGTON‡
WELCOME $750

	NON-SMOKER	SMOKER
Dependent child under 25*	$159	$159
Adult age 24 or under	$253	$303
25–29	$294	$354
30–34	$320	$383
35–39	$297	$355
40–44	$310	$372
45–49	$354	$425
50–54	$439	$526
55–59	$522	$626
60–64	$675	$809
65 +	$675	$809

	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$750 per member or $2,250 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 and mental health outpatient services.	■ $30 + 20%
PREVENTIVE CARE VISITS 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 non-routine prenatal and postpartum visits. Copay waived for routine care.	■ $30 + 20%
Delivery & associated hospital care.	$500 per day to 5 days/admit + 20%
LAB/X-RAY SERVICES	Deductible waived on first $500 PCY, then deductible and 20% apply.
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Includes mental health inpatient treatment.	$500 per day to 5 days/admit + 20%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)
PRESCRIPTION DRUGS – OUTPATIENT Drugs and medicines that require prescription, including self-administered 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.	$100 + 20%
Non-Group Health or non-Group Health–designated facilities worldwide, including urgent care facilities.	$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.

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Coverage provided by Group Health Cooperative.

WELCOME 1820

A HAPPY MEDIUM.

The Welcome 1820 Catastrophic Plan–'10 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.

Rates effective July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
WELCOME $1820

	NON-SMOKER	SMOKER
Dependent child under 25*	$77	$77
Adult age 24 or under	$91	$107
25–29	$100	$119
30–34	$109	$131
35–39	$120	$144
40–44	$147	$175
45–49	$172	$207
50–54	$208	$250
55–59	$255	$308
60–64	$327	$391
65 +	$327	$391

CENTRAL/EASTERN WASHINGTON‡
WELCOME $1820

	NON-SMOKER	SMOKER
Dependent child under 25*	$79	$79
Adult age 24 or under	$92	$110
25–29	$102	$121
30–34	$111	$133
35–39	$122	$148
40–44	$149	$180
45–49	$176	$211
50–54	$213	$254
55–59	$262	$315
60–64	$333	$399
65 +	$333	$399

	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$1,820 per member or $5,460 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 and mental health outpatient services.	■ 40%
PREVENTIVE CARE VISITS 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
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. Includes mental health inpatient treatment. Maternity care not covered.	40%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)
PRESCRIPTION DRUGS	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities.	$100 + 40%
Non–Group Health or non-Group Health–designated facilities worldwide, including urgent care facilities.	$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, 98559, & 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–'10 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 July 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2011.

WESTERN WASHINGTON‡
WELCOME $3500

	NON-SMOKER	SMOKER
Dependent child under 25*	$64	$64
Adult age 24 or under	$75	$89
25–29	$82	$97
30–34	$89	$107
35–39	$100	$119
40–44	$121	$145
45–49	$143	$172
50–54	$172	$207
55–59	$212	$254
60–64	$268	$322
65 +	$268	$322

CENTRAL/EASTERN WASHINGTON‡
WELCOME $3500

	NON-SMOKER	SMOKER
Dependent child under 25*	$65	$65
Adult age 24 or under	$76	$91
25–29	$83	$101
30–34	$92	$110
35–39	$102	$121
40–44	$123	$149
45–49	$146	$176
50–54	$176	$211
55–59	$217	$261
60–64	$275	$330
65 +	$275	$330

	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 and mental health outpatient services.	■ 50%
PREVENTIVE CARE VISITS 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
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. Includes mental health inpatient treatment. Maternity care not covered.	50%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)
PRESCRIPTION DRUGS	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities.	$100 + 50%
Non–Group Health or non-Group Health–designated facilities worldwide, including urgent care facilities.	$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, 98559, & 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 2750 Individual/5500 Family Catastrophic Plan–'10 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 office visits, no matter where you get care. Notice that the coinsurance is slightly lower if you opt for in-network care.

Rates effective June 1, 2010–June 30, 2011.
Rates based on age as of July 1, 2010.

WESTERN WASHINGTON‡
HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	$66	$66
Adult age 24 or under	$77	$92
25–29	$84	$101
30–34	$92	$111
35–39	$102	$122
40–44	$124	$150
45–49	$148	$177
50–54	$177	$213
55–59	$219	$262
60–64	$277	$332
65 +	$277	$332

CENTRAL/EASTERN WASHINGTON‡
HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	$68	$68
Adult age 24 or under	$78	$94
25–29	$87	$103
30–34	$94	$113
35–39	$105	$126
40–44	$127	$153
45–49	$151	$181
50–54	$182	$217
55–59	$223	$268
60–64	$283	$340
65 +	$283	$340

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$2,750 per member or $5,500 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 Includes mental health outpatient services.	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
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. Includes mental health inpatient treatment. Maternity care not covered.	10%	20%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% up to $5,000 in charges ($2,500 max. benefit PCY); Prosthetics—50% up to $40,000 in charges ($20,000 max. benefit PCY)	
PRESCRIPTION DRUGS	Not covered	Not covered
EMERGENCY CARE	10%	10%
VISION CARE	Not covered	Not covered
	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS 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, 98559, & 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: 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.

Optional dental

OPTIONAL 2010 PLAN YEAR #1126 (GHC) AND #00585 (GHO) SUMMARY OF BENEFITS

Those who are members of Group Health's* individual and family plans are eligible to enroll in the Washington Dental Service (WDS) PPO program. This WDS dental plan gives you the freedom to use any dentist with slightly better benefits if you see a PPO provider. 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 preapproved 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 nonparticipating 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	$50.96
Subscriber and child(ren)+	$96.20
Subscriber and spouse	$89.96
Subscriber and family+	$135.19

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.

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 an exemption under the law applies. In order to process your application for one of our individual and family plans, we must receive the 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 any Group Health individual and 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, for which a prudent person would have sought advice or treatment. Section 6 of the application for our individual and family plans 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 individual and family coverage from Group Health. The counties that are served by our individual and family plans 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 one of Group Health's individual and family plans, 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 a Group Health Cooperative individual and family plan to a 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.

Exclusions and limitations

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

Group Health's* plans for individuals and families 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 a waiver or reduction of the waiting period 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 your contract. This summary 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 and family plan sales staff, or your producer.

* 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 amount you pay for 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, 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 individual and family sales a call. Our representatives are ready to answer your questions.

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