Plans for individuals and families

SUMMARY OF BENEFITS EFFECTIVE: JULY 1, 2012 – DEC. 31, 2013

GroupHealth
Well beyond medicine®


Snoqualmie

It’s your life.
It’s your choice.

We all live our lives differently. Whether you go full speed ahead or take it nice and easy, finding health care that fits the way you and your family live is something that’s important to everyone.

That’s why we offer the choices you need to pick a plan that’s right for you. Having one of these at the ready means 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.

Let’s get started.

Welcome to Group Health

About your choices

This booklet is designed to help make picking a health care plan for you and your family a little easier because, let's face it, having the right one helps you live the life you want. If after reading this, you're still not sure which plan is best for you, you can always call us for help.

Inside, you'll find an explanation of the three types of plans we offer—Welcome, Balance, and HealthPays® HSA—rates, information about optional dental coverage, and some legalese. The chart below explains how everything breaks down, so these terms make sense as you turn the pages.

HEALTH PLAN CARRIER	GROUP HEALTH COOPERATIVE	GROUP HEALTH OPTIONS, INC.
HEALTH PLANS	• Welcome • HealthPays HSA	• Balance • HealthPays HSA
NETWORK	Group Health	Alliant Plus
MEDICAL GROUP	**IN-NETWORK:** Group Health Physicians, plus thousands of contracted community providers **OUT-OF-NETWORK:** Not available	**IN-NETWORK:** Group Health Physicians, Virginia Mason, The Everett Clinic **OUT-OF-NETWORK:** Any doctor in the U.S., plus discounted rates from First Choice Health® Network and First Health® Network

Physician groups

There are many physicians available to you regardless of the plan you pick, including the award-winning* doctors that make up Group Health Physicians (who are not available with any other health plan carrier). The chart below explains the medical groups and which networks give you access to each.

*The American Medical Group Association (AMGA) unanimously selected Group Health Physicians for the prestigious AMGA Acclaim Award, recognizing years of care excellence and innovative work and improvement. September 2010

IN-NETWORK:

- WELCOME PLANS
- GROUP HEALTH COOPERATIVE HEALTHPAYS HSA

GROUP HEALTH

All plans give you access to this in-network care consisting of 25 medical centers and more than 1,300 Group Health Physicians and clinicians, as well as more than 9,000 contracted providers.*

VIRGINIA MASON

This Alliant Plus in-network option includes access to 8 locations and more than 400 doctors.

THE EVERETT CLINIC

This Alliant Plus in-network option gives you access to 16 locations and almost 400 physicians.

IN-NETWORK:

- BALANCE PLANS
- GROUP HEALTH OPTIONS, INC. HEALTHPAYS HSA

FIRST CHOICE HEALTH

An Alliant Plus out-of-network option, offering discounted rates to more than 50,000 doctors in Washington, Oregon, Idaho, Alaska, and Montana.

FIRST HEALTH

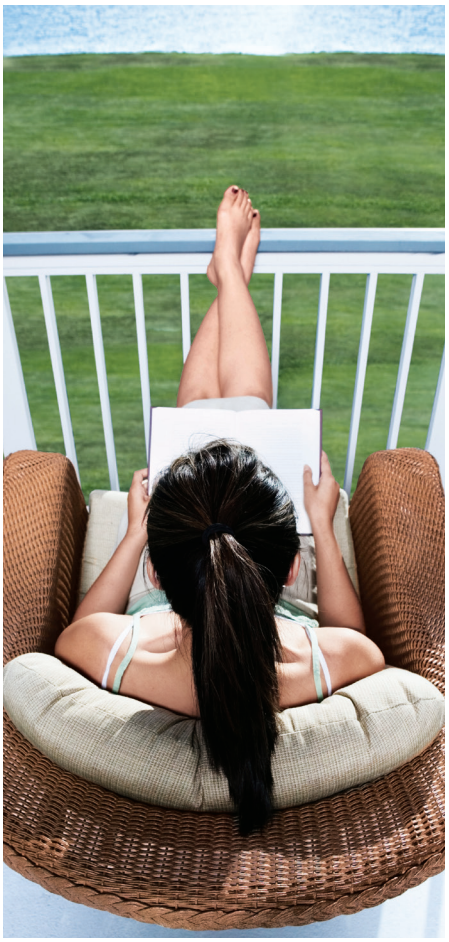
An Alliant Plus out-of-network option, offering discounted rates to more than 590,000 doctors, nationwide.

OUT-OF-NETWORK:

- BALANCE PLANS
- GROUP HEALTH OPTIONS, INC. HEALTHPAYS HSA

* Source: OIC Provider Form A

The Balance plans



If choice is first and foremost, the Balance plans are for you because **YOU CAN SEE ANY DOCTOR YOU WANT FOR PRIMARY, SPECIALTY, AND ALTERNATIVE CARE IN THE U.S.** These plans let you choose between the Alliant Plus in-network and out-of-network options, with different levels of coverage.

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.

BALANCE 1750 PLAN – '12

	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$172	$297	$361	$377	$348	$364	$416	$512	$611	$789	$789
WWA | Smoker	$172	$356	$432	$449	$417	$436	$497	$615	$735	$946	$946
CENTRAL/EWA‡ | Nonsmoker	$175	$303	$369	$383	$356	$372	$423	$525	$625	$810	$810
CENTRAL/EWA | Smoker	$175	$364	$442	$462	$428	$445	$510	$630	$752	$966	$966

BALANCE 2500 CATASTROPHIC PLAN – '12

	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$95	$120	$131	$147	$161	$195	$230	$276	$337	$427	$427
WWA | Smoker	$95	$145	$159	$173	$191	$235	$276	$329	$404	$511	$511
CENTRAL/EWA‡ | Nonsmoker	$97	$122	$135	$148	$163	$197	$237	$281	$343	$439	$439
CENTRAL/EWA | Smoker	$97	$148	$162	$177	$196	$239	$281	$337	$413	$527	$527

BALANCE 5000 CATASTROPHIC PLAN – '12

	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$78	$100	$107	$116	$129	$157	$184	$222	$273	$346	$346
WWA | Smoker	$78	$116	$128	$142	$155	$189	$222	$269	$326	$414	$414
CENTRAL/EWA‡ | Nonsmoker	$80	$101	$109	$120	$132	$160	$189	$229	$280	$355	$355
CENTRAL/EWA | Smoker	$80	$118	$130	$143	$159	$191	$229	$272	$333	$426	$426

‡ 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. Rates effective July 1, 2012 – December 31, 2013. Rates based on age as of July 1, 2012.

Note: For families where the primary subscriber is a smoker and is being billed at the smoking rate, the smoker is on a different contract than their spouse/domestic partner and dependent(s), even though they are on the same health plan. As a result, the deductible and out-of-pocket maximum are not combined and will accrue and be met independently.

	BALANCE 1750		BALANCE 2500		BALANCE 5000	
COVERAGE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$1,750 per member or $5,250 per family		$2,500 per member or $7,500 per family		$5,000 per member or $15,000 per family	
MEMBER COINSURANCE	20%	50%	40%	50%	50%	50%
OUT-OF-POCKET LIMIT+ Deductible does not apply	$6,000 per member or $18,000 per family		$8,000 per member or $24,000 per family		$10,000 per member or $30,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS	Primary: $30/visit Specialty: $50/visit	Primary: $30 + 50% Specialty: $50 + 50%	Primary: $30/visit Specialty: $50/visit	Primary: $30 + 50% Specialty: $50 + 50%	Primary: $30/visit Specialty: $50/visit	Primary: $30 + 50% Specialty: $50 + 50%
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	$30/visit	$30/visit + 50%	$30/visit	$30/visit + 50%	$30/visit	$30/visit + 50%
ACUPUNCTURE	$30/visit, up to 8 visits PCY	$30/visit + 50%	$30/visit, up to 8 visits PCY	$30/visit + 50%	$30/visit, up to 8 visits PCY	$30/visit + 50%
NATUROPATHY	$30/visit, up to 3 visits PCY	$30/visit + 50%	$30/visit, up to 3 visits PCY	$30/visit + 50%	$30/visit, up to 3 visits PCY	$30/visit + 50%
MATERNITY CARE Outpatient prenatal and postpartum visits.	Covered in full	$30/visit + 50%	Covered in full	$30/visit + 50%	Covered in full	$30/visit + 50%
	Delivery and associated care covered at hospital inpatient cost share.		Delivery and associated care at hospital not covered.		Delivery and associated care at hospital not covered.	
	AFTER DEDUCTIBLE, MEMBER PAYS		AFTER DEDUCTIBLE, MEMBER PAYS		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.	$300 per day up to 5 days/admit + 20%	$500 per day up to 5 days/admit + 50%	$100 per day up to 5 days/admit + 40%	$200 per day up to 5 days/admit + 50%	$100 per day up to 5 days/admit + 50%	$200 per day up to 5 days/admit + 50%
LAB/X-RAY SERVICES	Deductible waived on first $400 PCY, then deductible and 20% apply.	50%	Deductible waived on first $200 PCY, then deductible and 40% apply.	50%	Deductible waived on first $200 PCY, then deductible and 50% apply.	50%
DEVICES, EQUIPMENT & SUPPLIES DME and prosthetics	Covered at 50%	Covered at 50%	Covered at 50%	Covered at 50%	Covered at 50%	Covered at 50%
EMERGENCY CARE	$200 + 20%	$200 + 20%	$200 + 40%	$200 + 40%	$200 + 50%	$200 + 50%
	DEDUCTIBLE DOES NOT APPLY		DEDUCTIBLE DOES NOT APPLY		DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE SERVICES For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule. Includes formulary contraceptive drugs, contraceptive devices, and female sterilization.	Covered in full	$30/visit + 50% $300 individual/ $600 family annual benefit maximum	Covered in full	$30/visit + 50% $300 individual/ $600 family annual benefit maximum	Covered in full	$30/visit + 50% $300 individual/ $600 family annual benefit maximum
PRESCRIPTION DRUGS **Outpatient:** Formulary drugs and medicines that require prescription, including self-administered injectables, mental health drugs, and diabetic supplies.	$15 generic/40% brand-name **Mail order**: $5 discount for 30-day supply	$20 generic/40% brand-name	Not covered	Not covered	Not covered	Not covered
VISION CARE	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months	$30 for routine eye exam per 12 months	Covered up to $30 for routine eye exam per 12 months
	$150 hardware benefit per 24 months. Not subject to coinsurance or deductible.					

+ Member coinsurance and emergency care copayment apply. No other fees for covered services apply to out-of-pocket limit.
† PCY = per calendar year
CARRYOVER: there is no 4th quarter deductible carryover.

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. 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.

The Welcome plans

Coverage with the Welcome plans runs the gamut. You can opt for more coverage if you think you're going to use your health care often, or you can choose a plan with a higher deductible that offers simple catastrophic coverage, if you rarely experience health issues. Thinking about how you use your health care now will help you figure out which plan is right for you.

WELCOME 1000 PLAN – '12											
	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$172	$283	$306	$355	$334	$349	$399	$492	$587	$754	$754
WWA | Smoker	$172	$342	$370	$429	$401	$416	$478	$589	$701	$905	$905
CENTRAL/EWA‡ | Nonsmoker	$176	$291	$339	$368	$342	$355	$406	$503	$598	$775	$775
CENTRAL/EWA | Smoker	$176	$349	$406	$440	$408	$428	$489	$602	$718	$927	$927
WELCOME 2000 CATASTROPHIC PLAN – '12											
	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$83	$102	$114	$124	$135	$166	$193	$234	$286	$367	$367
WWA | Smoker	$83	$122	$134	$148	$162	$198	$233	$282	$345	$438	$438
CENTRAL/EWA‡ | Nonsmoker	$85	$103	$116	$126	$137	$168	$199	$240	$294	$374	$374
CENTRAL/EWA | Smoker	$85	$125	$136	$150	$167	$203	$237	$286	$353	$447	$447
WELCOME 3500 CATASTROPHIC PLAN – '12											
	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$70	$87	$95	$103	$115	$138	$164	$196	$243	$306	$306
WWA | Smoker	$70	$103	$111	$122	$136	$167	$196	$237	$290	$367	$367
CENTRAL/EWA‡ | Nonsmoker	$71	$88	$96	$105	$117	$141	$168	$201	$247	$314	$314
CENTRAL/EWA | Smoker	$71	$105	$116	$126	$138	$171	$201	$241	$298	$376	$376

‡ 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. Rates effective July 1, 2012 – December, 31, 2013. Rates based on age as of July 1, 2012.

Note: For families where the primary subscriber is a smoker and is being billed at the smoking rate, the smoker is on a different contract than their spouse/domestic partner and dependent(s), even though they are on the same health plan. As a result, the deductible and out-of-pocket maximum are not combined and will accrue and be met independently.

	WELCOME 1000	WELCOME 2000	WELCOME 3500
COVERAGE	GROUP HEALTH NETWORK	GROUP HEALTH NETWORK	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	$1,000 per member or $3,000 per family	$2,000 per member or $6,000 per family	$3,500 per member or $10,500 per family
MEMBER COINSURANCE	20%	40%	50%
OUT-OF-POCKET LIMIT+ Deductible does not apply	$5,000 per member or $15,000 per family	$6,000 per member or $18,000 per family	$10,000 per member or $30,000 per family
BENEFITS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS
	First 4 visits: You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until **after** the 4th visit for services indicated by ■	**First 4 visits:** You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until **after** the 4th visit for services indicated by ■	**First 4 visits:** You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until **after** the 4th visit for services indicated by ■
OFFICE VISITS	■ $30 + 20% | Primary care ■ $50 + 20% | Specialty care	■ $30 + 40% | Primary care ■ $50 + 40% | Specialty care	■ $30 + 50% | Primary care ■ $50 + 50% | Specialty care
PREVENTIVE CARE SERVICES For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule. Includes formulary contraceptive drugs, contraceptive devices, and female sterilization.	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full, deductible waived
MANIPULATIVE THERAPY	■ $30 + 20%, up to 10 visits PCY†	■ $30 + 40%, up to 10 visits PCY†	■ $30 + 50%, up to 10 visits PCY†
ACUPUNCTURE	■ $30 + 20%, up to 8 visits PCY	■ $30 + 40%, up to 8 visits PCY	■ $30 + 50%, up to 8 visits PCY
NATUROPATHY	■ $30 + 20%, up to 3 visits PCY	■ $30 + 40%, up to 3 visits PCY	■ $30 + 50%, up to 3 visits PCY
MATERNITY CARE Outpatient prenatal and postpartum visits.	Covered in full Delivery and associated hospital care: $500 per day to 5 days/admit + 20%	Covered in full Delivery and associated care at hospital not covered	Covered in full Delivery and associated care at hospital not covered
LAB/X-RAY SERVICES	Deductible waived on first $400 PCY, then deductible and 20% apply	Deductible waived on first $200 PCY, then deductible and 40% apply	Deductible waived on first $200 PCY, then deductible and 50% 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%	40%	50%
DEVICES, EQUIPMENT & SUPPLIES DME and prosthetics	50%	50%	50%
PRESCRIPTION DRUGS – OUTPATIENT Formulary drugs and medicines that require prescription, including self-administered injectables, mental health drugs, and diabetic supplies.	$15 copay generic/30% brand-name Not subject to deductible **Mail order:** $5 discount for 30-day supply	Not covered	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities. Non-Group Health or non-Group Health–designated facilities worldwide, including urgent care facilities.	$200 + 20% $200 + 20%	$200 + 40% $200 + 40%	$200 + 50% $200 + 50%
VISION CARE $150 hardware benefit per 24-month period. Hardware not subject to deductible or coinsurance.	■ $30 + 20% for routine eye exam	■ $30 + 40% for routine eye exam	■ $30 + 50% for routine eye exam

+ Member coinsurance and emergency care copayment apply. No other fees for covered services apply to out-of-pocket limit.

† PCY = per calendar year

CARRYOVER: there is no 4th quarter deductible carryover.

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. 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.

The HealthPays® HSA plans

THERE ARE TWO HEALTHPAYS HEALTH SAVINGS ACCOUNT PLANS FOR YOU TO CHOOSE FROM: One that gives you the Group Health in-network option, and one that gives you the Alliant Plus in- and out-of network options. Either way, you can pair your plan with a separate savings account designated for pretax money that you can use to pay eligible medical expenses.

You can choose your own financial institution or choose to use our partner, HealthEquity®. HealthEquity is one of the nation's oldest and largest dedicated savings account trustees, providing account administration support, live daily claims updates, online tools, and a 24/7 call center whenever help is needed. Visit www.healthequity.com or call 1-877-291-1936. Either way, you can be sure your money is safe.

THERE ARE A FEW ELIGIBILITY RULES: You can't be covered under another plan or enrolled in Medicare, and children under the age of 18 may enroll but won't be eligible for an associated savings account. 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.

For more information about health savings accounts, contact your tax or legal advisors.

GROUP HEALTH | HSA 2000 INDIVIDUAL/4000 FAMILY CATASTROPHIC PLAN – '12

	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$86	$104	$115	$124	$137	$168	$197	$236	$292	$368	$368
WWA | Smoker	$86	$124	$135	$149	$166	$201	$236	$284	$349	$442	$442
CENTRAL/EWA‡ | Nonsmoker	$89	$106	$117	$126	$140	$170	$203	$242	$299	$374	$374
CENTRAL/EWA | Smoker	$89	$127	$137	$151	$170	$207	$241	$288	$357	$451	$451

ALLIANT PLUS | HSA 2750 INDIVIDUAL/5500 FAMILY CATASTROPHIC PLAN – '12

	Dep. child under 26	Adult age 24 & under	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65+
WWA‡ | Nonsmoker	$92	$115	$125	$138	$152	$184	$219	$262	$323	$408	$408
WWA | Smoker	$92	$138	$151	$165	$182	$221	$262	$314	$386	$488	$488
CENTRAL/EWA‡ | Nonsmoker	$94	$116	$131	$140	$157	$189	$224	$269	$329	$417	$417
CENTRAL/EWA | Smoker	$94	$140	$153	$168	$188	$226	$268	$320	$394	$499	$499

‡ 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. Rates effective July 1, 2012 – December 31, 2013. Rates based on age as of July 1, 2012.

Note: For families where the primary subscriber is a smoker and is being billed at the smoking rate, the smoker is on a different contract than their spouse/domestic partner and dependent(s), even though they are on the same health plan. As a result, the deductible and out-of-pocket maximum are not combined and will accrue and be met independently.

	HEALTHPAYS 2000/4000 HSA – GROUP HEALTH	HEALTHPAYS 2750/5500 HSA – ALLIANT PLUS	
COVERAGE	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	$2,000 per member or $4,000 per family	$2,750 per member or $5,500 per family	
MEMBER COINSURANCE	20%	20%	50%
OUT-OF-POCKET LIMIT+	$6,050 per member or $12,100 per family	$6,050 per member or $12,100 per family	
BENEFITS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS Includes mental health outpatient services.	20%	20%	50%
MANIPULATIVE THERAPY	20%, up to 10 visits PCY†	20% Limit total visits PCY to 10 combined for both in- and out-of-network.	50%
ACUPUNCTURE	20%, up to 8 visits PCY	20%, up to 8 visits PCY	50%
NATUROPATHY	20%, up to 3 visits PCY	20%, up to 3 visits PCY	50%
MATERNITY CARE Outpatient prenatal and postpartum visits	Covered in full Delivery and associated care at hospital not covered.	Covered in full Delivery and associated care at hospital not covered.	50%
LAB/X-RAY SERVICES	20%	20%	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.	20%	20%	50%
DEVICES, EQUIPMENT & SUPPLIES DME and prosthetics	Covered at 50%	Covered at 50%	Covered at 50%
PRESCRIPTION DRUGS	Not covered	Not covered	Not covered
EMERGENCY CARE	20%	20%	20%
VISION CARE	Not covered	Not covered	Not covered
	DEDUCTIBLE DOES NOT APPLY	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE SERVICES For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule. Includes formulary contraceptive drugs, contraceptive devices, and female sterilization.	Covered in full	Covered in full	50% $300 individual/ $600 family annual benefit maximum

+ All fees for covered services apply to out-of-pocket limit.

† PCY = per calendar year

CARRYOVER: there is no 4th quarter deductible carryover.

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. 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 and Group Health Options, Inc.

Primary and specialty care

About your cost shares

Each of our individual and family plans gives you access to great doctors. The Welcome and Balance plans are designed with a lower copayment for the type of care that's needed most often. The list here explains the types of care that you'll pay a lower copay for, and the ones for which you'll pay a higher copay.

PRIMARY CARE | LOWER COST SHARE

Acupuncture
Audiology
Chemical Dependency/ Substance Abuse
Chiropractic
Emergency Medicine (where ER copay doesn't apply)
Enterostomal Therapy
Family Planning
Family Medicine
General Practice
Health Education
Internal Medicine
Massage Therapy
Mental Health
Midwifery
Naturopathy
Nutrition
Obstetrics & Gynecology
Occupational Medicine
Occupational Therapy
Optometry
Osteopathy
Pediatrics
Physical Therapy
Respiratory Therapy
Speech Therapy
Urgent Care
Women's Health Care

SPECIALTY CARE | HIGHER COST SHARE

Allergy & Immunology
Anesthesiology
Cardiology (Pediatric & cardiovascular disease)
Critical Care Medicine
Dentistry
Dermatology
Endocrinology
Gastroenterology
Genetics
Hepatology
Infectious Disease
Neonatal-Perinatal Medicine
Nephrology
Neurology
Hematology/Oncology
Ophthalmology
Orthopedics
ENT/Otolaryngology
Pathology
Physiatry (Physical Medicine)
Podiatry
Pulmonary Medicine/Disease
Radiology (Nuclear Medicine, Radiation Therapy)
Rheumatology
Sports Medicine
General Surgery (all specific surgeries)
Urology

Optional dental

OPTIONAL 2012 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)

DELTA DENTAL®
Washington Dental Service

MONTHLY RATES

Subscriber	$49.37
Subscriber and spouse	$93.21
Subscriber and child(ren)+	$87.19
Subscriber and family+	$131.03

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 prescription 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.

* Group Health refers to Group Health Cooperative or Group Health Options, Inc.
† $150 per family calendar year deductible.
+ Children under 3 are not required to enroll.

Exclusions and limitations

Yes, here's the fine print—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. These become 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
- 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 above 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 will help as you look through this summary and other communication you might receive from us.

AGE BAND
An age band is a range of ages. Each of our plans has rates that differ by age band. Your rate is based on your age as of July 1. As your plan renews, your age band might change from one year to the next. For example, if you are 39 when you enroll this year, you'll fall in the 35–39 age band and will pay the premium associated with that age band for the plan you choose. The following year, at the July 1 renewal, you'd move to the 40–44 age band and pay the rate associated with your new age band.

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. 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.

ESSENTIAL HEALTH BENEFITS
A set of health care service categories set forth under the Patient Protection and Affordable Care Act (2010) that must be covered by certain plans no later than January 1, 2014.

IN-NETWORK
This is care you receive from the more than 1,300 providers* at more than two dozen Group Health Medical Centers locations, or from thousands of contracted community providers. And, for the Balance plans and the Group Health Options HealthPays plan, 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 aged 65 and older, 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 directly for Group Health or who are not contracted with Group Health to provide in-network care. For the Balance and Group Health Options HealthPays HSA plans, you can see any doctor you want, anywhere in the U.S. Your coverage will be slightly less than if you receive care in-network. The Welcome and the Group Health Cooperative HealthPays HSA plans do not have an out-of-network option.

OUT-OF-POCKET LIMIT
This is the maximum you pay for certain covered services in a calendar year. Notice that each plan has different limits and only certain fees apply.

OUTPATIENT CARE
This is care you get that doesn't require you to stay in a hospital. It could be a visit to see your personal physician, an acupuncturist, a specialist, or day surgery where recovery can occur at home.

* Source: OIC Provider Form A

GroupHealth®

ghc.org/if
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.

193IF-2012-12W