

Group Health - Balance 1250

\$1,250 Deductible

Family deductible maximum is 3x individual deductible.



GroupHealth

All benefits shown below are out of network benefits using the First Choice network, www.fchn.com

(Beech Street nationwide). If you go outside the First Choice network, you will be responsible for amount billed above the allowed amount.

See Group Health summary for in-network benefits which include office visits and x-ray/lab without deductible.

Before the deductible is met: These benefits are not subject to the deductible:

- 1. Preventive Care is paid at 100% to \$300 per calendar year.**
Well adult and well child physicals, immunizations, pap smears, mammogram, prostate/colorectal cancer screening. (\$600 family annual benefit maximum)
- 2. Vision Care – \$30 of eye exam fee will be reimbursed per 12 months.**
Vision hardware is covered up to \$200 per 12 months, paid at 100%
- 3. Prescription Drugs – \$3,000 maximum** per person per calendar year (not subject to deductible)
Includes birth control pills and mental health drugs.

*Must use generic when there is an exact generic equivalent.

Tier 1 (Generic)	= \$15 retail co-pay, mail order available only in-network
Tier 2* (Brand Name Formulary)	= 30% co-pay for retail or mail order
Tier 3* (Non-Formulary)	= 50% co-pay for retail or mail order

After the deductible has been met, all other covered benefits are provided.

- **Office Visits \$30 co-pay**
- **Lab and X-ray services 100%**
- **\$150 Emergency room co-pay** (waived if admitted), plus 20% co-insurance.
- **20% co-insurance for hospital and physician services**
- **Hospital inpatient co-pay of \$200 per day up to first 5 days per admission.**
- **\$5,000 annual co-insurance max,** plus deductible and co-pays (After deductible, you pay 20% of the next 25,000 (\$5,000 max), then Group Health covers 100% of allowable charges to 2 million)
- **2 million lifetime maximum**
- **Inpatient rehabilitation – 30 days PCY**
- **Outpatient rehabilitation - 60 visits PCY** (including massage therapy)
- **Includes inpatient/outpatient mental health**
- **Includes 24 hour “on the job” coverage** Subscriber only (if not covered by L&I)
- **Includes maternity coverage**
- Spinal manipulations, 10 PCY, \$30 co-pay
- Acupuncture, 8 PCY, \$30 co-pay
- Naturopath, 3 visits PCY, \$30 co-pay

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

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

*This flyer was prepared by the **Health Insurance Connection, Inc.**

(253) 848-7653

www.healthinswa.com

This is a brief summary of benefits and is not a certificate of coverage. For full coverage provisions, including a description of waiting periods and limitations, refer to a benefit brochure and contract. This summary is not a contract.

Rates guaranteed until July 1, 2011.

05/10

Group Health - Balance 1750

\$1,750 Deductible

Family deductible maximum is 3x individual deductible.



GroupHealth

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After the deductible has been met, all other covered benefits are provided.

- **Office Visits \$30 co-pay**
- **Lab and X-ray services 100%**
- **\$150 Emergency room co-pay (waived if admitted), plus 30% co-insurance.**
- **30% co-insurance for hospital and physician services**
- **Hospital inpatient co-pay of \$200 per day up to first 5 days per admission**
- **\$6,000 annual co-insurance max, plus deductible & co-pays**
(After deductible, you pay 30% of the next 20,000 (\$6,000 max), then Group Health covers 100% of allowable charges to 2 million)
- **2 million lifetime maximum**
- **Inpatient rehabilitation – 30 days PCY**
- **Outpatient rehabilitation - 60 visits PCY**
(including massage therapy)
- **Includes inpatient & outpatient mental health**
- **Includes 24 hour “on the job” coverage**
Subscriber only (if not covered by L&I)
- **Includes maternity coverage**
- **Spinal manipulations, 10 PCY, \$30 co-pay**
- **Acupuncture, 8 PCY, \$30 co-pay**
- **Naturopath, 3 visits PCY, \$30 co-pay**

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

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

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Rates guaranteed until July 1, 2011.

05/10

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%	
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.

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.

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
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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%
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OUT-OF-POCKET LIMIT [†] Deductible does not apply.	\$6,000 per member or \$18,000 per family	
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BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
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OFFICE VISITS Including mental health outpatient services.	\$30/visit	\$30/visit
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MANIPULATIVE THERAPY Limit total visits PCY [†] to 10 combined for both in- and out-of-network.	\$30/visit	\$30/visit
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ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit
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NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit
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MATERNITY CARE Outpatient non-routine prenatal and postpartum visits. Copay waived for routine care.	\$30/visit	\$30/visit
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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%
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LAB/X-RAY SERVICES	Deductible waived on first \$500 PCY, then deductible and 30% apply.	30%
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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)	
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EMERGENCY CARE	\$100 + 30%	\$150 + 30%
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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
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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
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‡ 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.

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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

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 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.

[†]Children under 3 are not required to enroll.

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.

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