

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.

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
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%
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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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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
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