

# Group Health - Healthpays HSA



# GroupHealth

All benefits shown below are “out of network” benefits using the First Choice network. [www.fchn.com](http://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 Alliant Plus in-network benefits which are 90% coverage and unlimited preventive benefit.

## Deductible Options:

**Individual Plan** \$2,750 deductible for individual / \$2,350 co-insurance maximum

**Family Plan** \$5,500 deductible for family / \$4,700 co-insurance maximum

**Deductible is waived and services paid with 20% co-insurance for preventive care.**

\$300 individual/\$600 family annual benefit maximum. (Well adult and well child physicals, preventive diagnostic lab, immunizations, pap smears, prostate/colorectal cancer screening)

Deductible is waived for mammogram only at a Group Health facility.

**All other services, paid AFTER deductible is met**

- Office visits - you pay 20% co-insurance
- Hospital and Physician Services – you pay 20% co-insurance
- Emergency care – you pay 10% co-insurance
- Out-of-Pocket Maximum = Deductible plus co-insurance maximum

## Notes regarding coverage:

- 2 million lifetime maximum
- Inpatient physical therapy – 30 days PCY
- Outpatient - 60 visits PCY
- Includes inpatient and outpatient mental health
- Spinal manipulations, 10 PCY
- Acupuncture, 8 visits PCY
- Naturopath, 3 visits PCY
- No fourth quarter deductible “carry-over”
- Includes occupational injury coverage. Subscriber only (if not covered by L&I)

## Partial list of Exclusions

Maternity, vision, prescription drugs

## WESTERN WASHINGTON<sup>‡</sup> 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

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](http://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

# 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<sup>‡</sup> HEALTHPAYS HSA

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50–54	\$177	\$213
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60–64	\$277	\$332
65 +	\$277	\$332

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> 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
<b>ANNUAL DEDUCTIBLE</b>	\$2,750 per member or \$5,500 per family	
<b>MEMBER COINSURANCE</b>	10%	20%
<b>OUT-OF-POCKET LIMIT<sup>†</sup></b> Deductible included	\$5,100 per member or \$10,200 per family	
BENEFITS AFTER DEDUCTIBLE, MEMBER PAYS		
<b>OFFICE VISITS</b> Includes mental health outpatient services.	10%	20%
<b>MANIPULATIVE THERAPY</b> Limit total visits PCY <sup>†</sup> to 10 combined for both in- and out-of-network.	10%	20%
<b>ACUPUNCTURE</b>	10%, up to 8 visits PCY	20%
<b>NATUROPATHY</b>	10%, up to 3 visits PCY	20%
<b>MATERNITY CARE</b>	Not covered	Not covered
<b>LAB/X-RAY SERVICES</b>	10%	20%
<b>HOSPITAL VISITS – INPATIENT</b> 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%
<b>DEVICES, EQUIPMENT &amp; SUPPLIES</b> (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)	
<b>PRESCRIPTION DRUGS</b>	Not covered	Not covered
<b>EMERGENCY CARE</b>	10%	10%
<b>VISION CARE</b>	Not covered	Not covered
DEDUCTIBLE DOES NOT APPLY		
<b>PREVENTIVE CARE VISITS</b> 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<sup>†</sup> 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<sup>†</sup> 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)

<sup>†</sup>\$150 per family calendar year deductible maximum

## **DELTA DENTAL** **Washington Dental Service**

### MONTHLY RATES

Subscriber	\$50.96
Subscriber and child(ren) <sup>†</sup>	\$96.20
Subscriber and spouse	\$89.96
Subscriber and family <sup>†</sup>	\$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.

<sup>†</sup>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.

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