

# Live your life

Individual & Family plans  
a summary of benefits





the doctor you want + the plan you want =

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.

## Individual & Family plans that help you do what you want to do.

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, including First Choice or Beech Street networks.

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 any preventive care services either in- or out-of-network, or to most in-network office visits, which is a whole lot of value.

\*Source: OIC Provider List Form A

## 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

## The HealthPays™ Health Savings Account

This plan 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 you want.

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.

# BALANCE 1000

## THE MOST COVERAGE.

The Balance 1000 Plan-'08 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 (in- or out-of-network), or to most in-network office visits. So you get a lot of coverage without first having to meet your deductible.

Rates effective July 1, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> BALANCE \$1000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$113	\$113
Adult age 24 or under	\$180	\$216
25 - 29	\$218	\$262
30 - 34	\$228	\$273
35 - 39	\$211	\$253
40 - 44	\$220	\$264
45 - 49	\$251	\$302
50 - 54	\$311	\$374
55 - 59	\$371	\$445
60 - 64	\$479	\$575
65 +	\$479	\$575

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> BALANCE \$1000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$115	\$115
Adult age 24 or under	\$184	\$221
25 - 29	\$223	\$268
30 - 34	\$233	\$279
35 - 39	\$216	\$259
40 - 44	\$225	\$270
45 - 49	\$257	\$309
50 - 54	\$319	\$382
55 - 59	\$380	\$456
60 - 64	\$490	\$588
65 +	\$490	\$588

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>	\$1,000 per member or \$3,000 per family	
<b>MEMBER COINSURANCE</b>	20%	20%
<b>OUT-OF-POCKET LIMIT<sup>+</sup></b>	\$4,000 per member or \$12,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
<b>OFFICE VISITS</b>	\$30/visit	\$30/visit
<b>MANIPULATIVE THERAPY</b>	\$30/visit, up to 10 visits PCY <sup>†</sup>	\$30/visit, up to 10 visits PCY
<b>ACUPUNCTURE</b>	\$30/visit, up to 8 visits PCY	\$30/visit
<b>NATUROPATHY</b>	\$30/visit, up to 3 visits PCY	\$30/visit
<b>MATERNITY CARE</b> Outpatient prenatal and postpartum visits.	\$30/visit	\$30/visit
<b>MENTAL HEALTH SERVICES</b> <b>Outpatient:</b> Limit total visits PCY to 12 combined for both in- and out-of-network.	\$30/visit	\$30/visit
<b>LAB/X-RAY SERVICES</b>	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
<b>MATERNITY CARE</b> Delivery & associated hospital care.	20%	20%
<b>MENTAL HEALTH SERVICES</b> <b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	20%	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.	20%	20%
<b>EMERGENCY CARE</b>	\$100 + 20%	\$150 + 20%
	DEDUCTIBLE DOES NOT APPLY	
<b>PREVENTIVE CARE</b> 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
<b>PRESCRIPTION DRUGS</b> <b>Outpatient:</b> Drugs and medicines that require prescription, including 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 <b>Mail order:</b> \$5 discount for 30-day supply	\$15 generic/30% brand name 50% non-formulary
<b>VISION CARE</b> \$200 hardware benefit per 12 months. Not subject to coinsurance.	\$30 for routine eye exam	\$30 of eye exam fee reimbursed per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit. Deductible does not 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, 98554, & 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 1500

## LOTS OF COVERAGE.

The Balance 1500 Plan-'08 is a comprehensive 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 1000 plan, but your premium will be lower. But remember, your deductible doesn't apply to preventive care (in- or out-of-network), or to most in-network office visits, so you get a lot of coverage without your deductible coming into play.

Rates effective July 1, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> BALANCE \$1500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$95	\$95
Adult age 24 or under	\$152	\$182
25 - 29	\$184	\$221
30 - 34	\$192	\$230
35 - 39	\$178	\$213
40 - 44	\$186	\$223
45 - 49	\$212	\$255
50 - 54	\$263	\$315
55 - 59	\$313	\$376
60 - 64	\$404	\$485
65 +	\$404	\$485

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> BALANCE \$1500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$97	\$97
Adult age 24 or under	\$155	\$186
25 - 29	\$188	\$226
30 - 34	\$196	\$236
35 - 39	\$182	\$218
40 - 44	\$190	\$228
45 - 49	\$217	\$261
50 - 54	\$269	\$323
55 - 59	\$321	\$385
60 - 64	\$414	\$496
65 +	\$414	\$496

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
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ANNUAL DEDUCTIBLE	\$1,500 per member or \$4,500 per family	
MEMBER COINSURANCE	30%	30%
OUT-OF-POCKET LIMIT <sup>+</sup>	\$6,000 per member or \$18,000 per family	

BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
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OFFICE VISITS	\$30/visit	\$30/visit
MANIPULATIVE THERAPY	\$30/visit, up to 10 visits PCY <sup>†</sup>	\$30/visit, up to 10 visits PCY
ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit
NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit
MATERNITY CARE Outpatient prenatal and postpartum visits.	\$30/visit	\$30/visit
MENTAL HEALTH SERVICES <b>Outpatient:</b> Limit total visits PCY to 12 combined for both in- and out-of-network.	\$30/visit	\$30/visit
LAB/X-RAY SERVICES	Covered in full	Covered in full

	AFTER DEDUCTIBLE, MEMBER PAYS	
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MATERNITY CARE Delivery & associated hospital care.	30%	30%
MENTAL HEALTH SERVICES <b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	30%	30%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.	30%	30%
EMERGENCY CARE	\$100 + 30%	\$150 + 30%

	DEDUCTIBLE DOES NOT APPLY	
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PREVENTIVE CARE 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 <b>Outpatient:</b> Drugs and medicines that require prescription, including 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 <b>Mail order:</b> \$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	\$30 of eye exam fee reimbursed per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit. Deductible does not 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, 98554, & 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—'08 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 (in- or out-of-network), or to most in-network office visits.

Rates effective July 1, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> BALANCE \$2500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$53	\$53
Adult age 24 or under	\$62	\$74
25 - 29	\$68	\$82
30 - 34	\$75	\$90
35 - 39	\$83	\$99
40 - 44	\$101	\$121
45 - 49	\$119	\$143
50 - 54	\$143	\$172
55 - 59	\$176	\$211
60 - 64	\$224	\$268
65 +	\$224	\$268

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> BALANCE \$2500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$55	\$55
Adult age 24 or under	\$63	\$76
25 - 29	\$70	\$84
30 - 34	\$76	\$92
35 - 39	\$85	\$102
40 - 44	\$103	\$124
45 - 49	\$122	\$146
50 - 54	\$146	\$176
55 - 59	\$180	\$216
60 - 64	\$229	\$275
65 +	\$229	\$275

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>	\$2,500 per member or \$7,500 per family	
<b>MEMBER COINSURANCE</b>	40%	40%
<b>OUT-OF-POCKET LIMIT<sup>+</sup></b>	\$8,000 per member or \$24,000 per family	
<b>BENEFITS</b>	<b>NO DEDUCTIBLE</b>	<b>AFTER DEDUCTIBLE, MEMBER PAYS</b>
<b>OFFICE VISITS</b>	\$30/visit	\$30/visit
<b>MANIPULATIVE THERAPY</b>	\$30/visit, up to 10 visits PCY <sup>†</sup>	\$30/visit, up to 10 visits PCY
<b>ACUPUNCTURE</b>	\$30/visit, up to 8 visits PCY	\$30/visit
<b>NATUROPATHY</b>	\$30/visit, up to 3 visits PCY	\$30/visit
<b>MATERNITY CARE</b>	Not covered	Not covered
<b>MENTAL HEALTH SERVICES</b> <b>Outpatient:</b> Limit total visits PCY to 12 combined for both in- and out-of-network.	\$30/visit	\$30/visit
<b>LAB/X-RAY SERVICES</b>	Covered in full	Covered in full
	<b>AFTER DEDUCTIBLE, MEMBER PAYS</b>	
<b>MENTAL HEALTH SERVICES</b> <b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	40%	40%
<b>HOSPITAL VISITS – INPATIENT</b> Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	40%	40%
<b>EMERGENCY CARE</b>	\$100 + 40%	\$150 + 40%
	<b>DEDUCTIBLE DOES NOT APPLY</b>	
<b>PREVENTIVE CARE</b> 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
<b>PRESCRIPTION DRUGS</b>	Not covered	Not covered
<b>VISION CARE</b> Hardware not covered.	\$30 for routine eye exam	\$30 of eye exam fee reimbursed per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit. Deductible does not 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, 98554, & 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-'08 has the highest deductible of any Balance plan, making it a true catastrophic 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 (in- or out-of-network), or for most in-network office visits, so this plan might give you all the coverage you need.

Rates effective July 1, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> BALANCE \$5000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$45	\$45
Adult age 24 or under	\$52	\$62
25 - 29	\$57	\$68
30 - 34	\$62	\$75
35 - 39	\$69	\$83
40 - 44	\$84	\$101
45 - 49	\$99	\$119
50 - 54	\$119	\$143
55 - 59	\$147	\$176
60 - 64	\$186	\$224
65 +	\$186	\$224

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> BALANCE \$5000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$46	\$46
Adult age 24 or under	\$53	\$63
25 - 29	\$58	\$70
30 - 34	\$64	\$76
35 - 39	\$71	\$85
40 - 44	\$86	\$103
45 - 49	\$101	\$122
50 - 54	\$122	\$146
55 - 59	\$150	\$180
60 - 64	\$191	\$229
65 +	\$191	\$229

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>	\$5,000 per member or \$15,000 per family	
<b>MEMBER COINSURANCE</b>	50%	50%
<b>OUT-OF-POCKET LIMIT<sup>+</sup></b>	\$10,000 per member or \$30,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
<b>OFFICE VISITS</b>	\$30/visit	\$30/visit
<b>MANIPULATIVE THERAPY</b>	\$30/visit, up to 10 visits PCY <sup>†</sup>	\$30/visit, up to 10 visits PCY
<b>ACUPUNCTURE</b>	\$30/visit, up to 8 visits PCY	\$30/visit
<b>NATUROPATHY</b>	\$30/visit, up to 3 visits PCY	\$30/visit
<b>MATERNITY CARE</b>	Not covered	Not covered
<b>MENTAL HEALTH SERVICES</b> <b>Outpatient:</b> Limit total visits PCY to 12 combined for both in- and out-of-network.	\$30/visit	\$30/visit
<b>LAB/X-RAY SERVICES</b>	Covered in full	Covered in full
	AFTER DEDUCTIBLE, MEMBER PAYS	
<b>MENTAL HEALTH SERVICES</b> <b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	50%	50%
<b>HOSPITAL VISITS – INPATIENT</b> Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.	50%	50%
<b>EMERGENCY CARE</b>	\$100 + 50%	\$150 + 50%
	DEDUCTIBLE DOES NOT APPLY	
<b>PREVENTIVE CARE</b> 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
<b>PRESCRIPTION DRUGS</b>	Not covered	Not covered
<b>VISION CARE</b> Hardware not covered.	\$30 for routine eye exam	\$30 of eye exam fee reimbursed per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit. Deductible does not 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, 98554, & 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 500

## THE MOST COVERAGE.

The Welcome 500 Plan-'08 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 \$500 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, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> WELCOME \$500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$131	\$131
Adult age 24 or under	\$208	\$250
25 - 29	\$226	\$272
30 - 34	\$262	\$315
35 - 39	\$245	\$294
40 - 44	\$256	\$307
45 - 49	\$292	\$350
50 - 54	\$361	\$434
55 - 59	\$431	\$517
60 - 64	\$556	\$667
65 +	\$556	\$667

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> WELCOME \$500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$134	\$134
Adult age 24 or under	\$213	\$256
25 - 29	\$249	\$299
30 - 34	\$270	\$324
35 - 39	\$250	\$300
40 - 44	\$262	\$314
45 - 49	\$299	\$358
50 - 54	\$370	\$444
55 - 59	\$441	\$529
60 - 64	\$569	\$683
65 +	\$569	\$683

## GROUP HEALTH NETWORK

**ANNUAL DEDUCTIBLE** \$500 per person or \$1,500 per family

**MEMBER COINSURANCE** 20%

**OUT-OF-POCKET LIMIT\*\*** \$4,000 per person 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** ♦ \$30 + 20%  
Includes urgent care.

**PREVENTIVE CARE** ♦ \$30 + 20%  
For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.

**MANIPULATIVE THERAPY** ♦ \$30 + 20%, up to 10 visits PCY<sup>†</sup>

**ACUPUNCTURE** ♦ \$30 + 20%, up to 8 visits PCY

**NATUROPATHY** ♦ \$30 + 20%, up to 3 visits PCY

**MATERNITY CARE** ♦ \$30 + 20%  
Outpatient prenatal and postpartum visits.  
Delivery & associated hospital care. \$500 per day to 5 days/admit + 20%

**MENTAL HEALTH SERVICES – INPATIENT** \$500 per day to 5 days/admit + 20% coinsurance  
Up to 12 days PCY

**MENTAL HEALTH SERVICES – OUTPATIENT** ♦ \$30 + 20%, up to 12 visits PCY

**LAB/X-RAY SERVICES** First \$500 PCY covered in full  
Then 20% and deductible apply

**HOSPITAL VISITS – INPATIENT** \$500 per day to 5 days/admit + 20% coinsurance  
Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.

**PRESCRIPTION DRUGS – OUTPATIENT** \$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** \$100 + 20%  
Group Health or Group Health–designated facilities.  
\$150 + 20%  
Non-Group Health or non-Group Health–designated facilities worldwide.

**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. Deductible is not included in out-of-pocket limit.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

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Coverage provided by Group Health Cooperative.

# WELCOME 1750

## A HAPPY MEDIUM.

The Welcome 1750 Catastrophic Plan—'08 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 \$1,750 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, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> WELCOME \$1750

	NON-SMOKER	SMOKER
Dependent child under 25*	\$63	\$63
Adult age 24 or under	\$74	\$88
25 - 29	\$81	\$97
30 - 34	\$89	\$107
35 - 39	\$98	\$118
40 - 44	\$120	\$143
45 - 49	\$141	\$169
50 - 54	\$170	\$204
55 - 59	\$209	\$251
60 - 64	\$266	\$319
65 +	\$266	\$319

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> WELCOME \$1750

	NON-SMOKER	SMOKER
Dependent child under 25*	\$65	\$65
Adult age 24 or under	\$75	\$90
25 - 29	\$83	\$99
30 - 34	\$91	\$109
35 - 39	\$100	\$121
40 - 44	\$122	\$147
45 - 49	\$144	\$173
50 - 54	\$174	\$208
55 - 59	\$214	\$257
60 - 64	\$272	\$326
65 +	\$272	\$326

GROUP HEALTH NETWORK	
ANNUAL DEDUCTIBLE	\$1,750 per person or \$5,250 per family
MEMBER COINSURANCE	40%
OUT-OF-POCKET LIMIT**	\$6,000 per person or \$18,000 per family
BENEFITS	AFTER DEDUCTIBLE, MEMBER PAYS
	<b>First 5 visits:</b> You pay 40% coinsurance. Your deductible does not apply until <b>after</b> the 5th visit for services indicated by ■
OFFICE VISITS Includes urgent care.	■ 40%
PREVENTIVE CARE 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 <sup>†</sup>
ACUPUNCTURE	■ 40%, up to 8 visits PCY
NATUROPATHY	■ 40%, up to 3 visits PCY
MATERNITY CARE	Not covered
MENTAL HEALTH SERVICES – INPATIENT	40%, up to 12 days PCY
MENTAL HEALTH SERVICES – OUTPATIENT	■ 40%, up to 12 visits PCY
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. Maternity care not covered.	40%
PRESCRIPTION DRUGS	Not covered
EMERGENCY CARE Group Health or Group Health–designated facilities. Non-Group Health or non-Group Health–designated facilities worldwide.	\$100 + 40% \$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. Deductible is not included in out-of-pocket limit.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

NOTE: 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-'08 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, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> WELCOME \$3500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$52	\$52
Adult age 24 or under	\$61	\$73
25 - 29	\$67	\$80
30 - 34	\$73	\$88
35 - 39	\$81	\$97
40 - 44	\$99	\$118
45 - 49	\$116	\$140
50 - 54	\$140	\$168
55 - 59	\$173	\$207
60 - 64	\$219	\$263
65 +	\$219	\$263

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> WELCOME \$3500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$53	\$53
Adult age 24 or under	\$62	\$74
25 - 29	\$68	\$82
30 - 34	\$75	\$90
35 - 39	\$83	\$99
40 - 44	\$101	\$121
45 - 49	\$119	\$143
50 - 54	\$143	\$172
55 - 59	\$177	\$212
60 - 64	\$224	\$269
65 +	\$224	\$269

## GROUP HEALTH NETWORK

ANNUAL DEDUCTIBLE \$3,500 per person or \$10,500 per family

MEMBER COINSURANCE 50%

OUT-OF-POCKET LIMIT\*\* \$10,000 per person 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 ● 50%  
Includes urgent care.

PREVENTIVE CARE ● 50%  
For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.

MANIPULATIVE THERAPY ● 50%, up to 10 visits PCY<sup>†</sup>

ACUPUNCTURE ● 50%, up to 8 visits PCY

NATUROPATHY ● 50%, up to 3 visits PCY

MATERNITY CARE Not covered

MENTAL HEALTH SERVICES – INPATIENT 50%, up to 12 days PCY

MENTAL HEALTH SERVICES – OUTPATIENT ● 50%, up to 12 visits PCY

LAB/X-RAY SERVICES 50%

HOSPITAL VISITS – INPATIENT 50%  
Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital. Maternity care not covered.

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. \$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. Deductible is not included in out-of-pocket limit.

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 98554, & 98568). Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane.

NOTE: 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 2000 Individual/4000 Family Catastrophic Plan-'08 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, no matter whether you get care in- or out-of-network. Notice that the coinsurance is slightly lower if you opt for in-network care.

Rates effective July 1, 2008–June 30, 2009.  
Rates based on age as of July 1, 2008.

### WESTERN WASHINGTON<sup>‡</sup> HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	\$51	\$51
Adult age 24 or under	\$59	\$71
25 - 29	\$65	\$78
30 - 34	\$71	\$86
35 - 39	\$79	\$95
40 - 44	\$96	\$115
45 - 49	\$113	\$136
50 - 54	\$136	\$164
55 - 59	\$168	\$202
60 - 64	\$213	\$256
65 +	\$213	\$256

### CENTRAL/EASTERN WASHINGTON<sup>‡</sup> HEALTHPAYS HSA

	NON-SMOKER	SMOKER
Dependent child under 25*	\$52	\$52
Adult age 24 or under	\$60	\$73
25 - 29	\$67	\$80
30 - 34	\$73	\$88
35 - 39	\$81	\$97
40 - 44	\$98	\$118
45 - 49	\$116	\$139
50 - 54	\$140	\$167
55 - 59	\$172	\$206
60 - 64	\$218	\$262
65 +	\$218	\$262

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$2,000 per member or \$4,000 per family	
MEMBER COINSURANCE	10%	20%
OUT-OF-POCKET LIMIT <sup>+</sup>	\$5,100 per member or \$10,200 per family	
BENEFITS		
AFTER DEDUCTIBLE, MEMBER PAYS		
OFFICE VISITS	10%	20%
MANIPULATIVE THERAPY	10%, up to 10 visits PCY <sup>†</sup>	20%, up to 10 visits PCY
ACUPUNCTURE	10%, up to 8 visits PCY	20%
NATUROPATHY	10%, up to 3 visits PCY	20%
MATERNITY CARE	Not covered	Not covered
<b>MENTAL HEALTH SERVICES</b>		
<b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	10%	20%
<b>MENTAL HEALTH SERVICES</b>		
<b>Outpatient:</b> Limit total visits PCY to 12 combined for both in- and out-of-network.	10%	20%
LAB/X-RAY SERVICES	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. Maternity care not covered.	10%	20%
PRESCRIPTION DRUGS	Not covered	Not covered
EMERGENCY CARE	10%	10%
VISION CARE	Not covered	Not covered
DEDUCTIBLE DOES NOT APPLY		
<b>PREVENTIVE CARE</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, 98554, & 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:** Children under 18 can not enroll as primary subscriber.

**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.

**2008 PLAN YEAR #1126 AND #00585 SUMMARY OF BENEFITS**

Group Health's\* Individual & Family plan members are eligible to enroll in the Washington Dental Service (WDS) Premier Network program. This WDS dental plan gives you the freedom to use any dentist. 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 pre-approved 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. Check with your dentist to see if he or she is part of the Premier Network.

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 non participating 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.†****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.†****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

**MONTHLY RATES**

Subscriber	\$48.28
Subscriber and child(ren)	\$85.22
Subscriber and spouse	\$91.13
Subscriber and family	\$128.07

**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

# 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 exempt by the questionnaire's requirements. In order to process your application, Group Health must receive the Individual & Family plan application signed by you and your spouse/domestic partner, the signed questionnaire(s) for each family member to be enrolled, the first month's premium payment, 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 Marketing 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:** The first month's premium payment for all family members must be included with your application. You may pay by credit card (see Section 3 of the application), or by check or money order. If you are signing as a Guarantor, please see #2 above. All future 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. 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 the Individual & 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, or for a condition for which symptoms existed within the six-month period prior to the date of coverage for which a prudent person would have sought advice or treatment within the six months prior to the effective date of coverage. Section 6 of the Individual & Family Plan application 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 by a plan with no more than a \$1,750 deductible and with maternity and prescription drug benefits within the last 63 days, we may waive pre-existing conditions or credit that coverage. If you had a 64-day-or-more break in coverage or have been covered by a plan with more than a \$1,750 deductible and no maternity or prescription drug benefit, 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 coverage from the Group Health Individual & Family Plan. The counties that are served by the Individual & Family Plan 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 with the Group Health Individual & Family Plan, 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 an Individual & Family Group Health Cooperative plan to an Individual & Family Group Health Options, Inc. plan, you and your dependents will be required to complete a new Standard Health Questionnaire.
- 12. Adding dependents:** 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.**

The Individual & Family plans for Group Health\* 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 portability on pre-existing conditions 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 this contract. This information 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 & Family Plan sales staff, or your broker/agent.

\* 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 of 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.

**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, this means 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.

**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.



**[www.ghc.org](http://www.ghc.org)**  
**1-800-358-8815**

Remember, this is just a summary, so if you need more information or just another definition, give I&F Sales a call. Our representatives are ready to answer your questions.