

Individual and Family HEALTHPAYS HSA PLAN



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[‡] 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

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

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.

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