

Plans for individuals and families

SUMMARY OF BENEFITS EFFECTIVE: JULY 1, 2011 – JUNE 30, 2012





It's your life. It's your choice.

We all live our lives differently. Whether you go full speed ahead or take it nice and easy, finding health care that fits the way you and your family live is something that's important to us all.

That's why we offer the choices you need to pick a plan that's right for you. Having one of these in your back pocket means 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.

Let's get started.



Welcome to Group Health

About your choices

This booklet is designed to help make picking a health care plan for you and your family a little easier because, let's face it, having the right one is key to living the life you want. If after reading this, you're still not sure which plan is best for you, we're always available by phone.

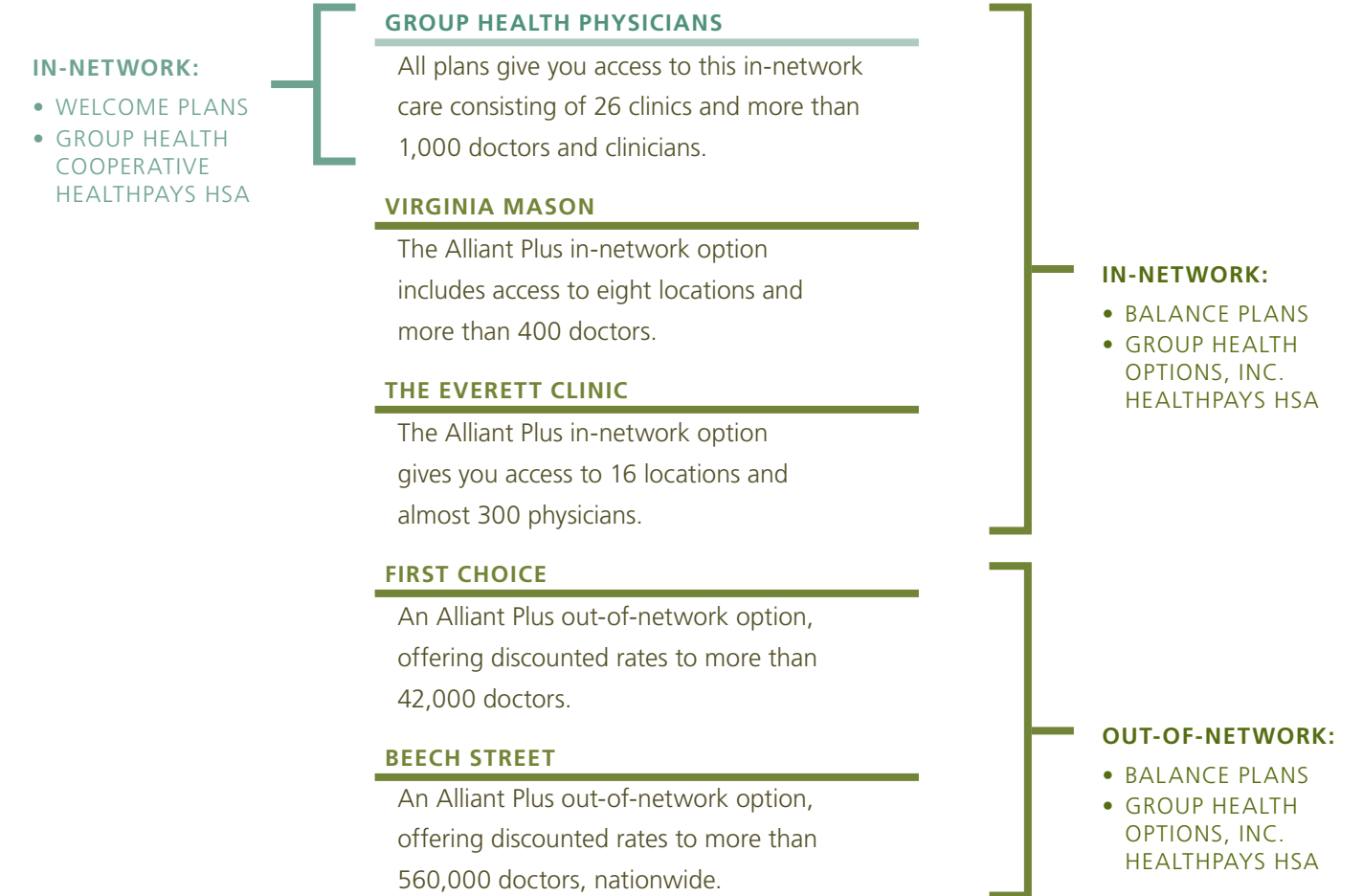
Inside, you'll find an explanation of the three types of plans we offer: Welcome, Balance, and HealthPays® HSA plans, rates, information about optional dental coverage, and some legalese. The chart below explains how everything breaks down, so that these terms make sense as you turn the pages.

HEALTH PLAN CARRIER	GROUP HEALTH COOPERATIVE	GROUP HEALTH OPTIONS, INC.
HEALTH PLANS	<ul style="list-style-type: none"> Welcome HealthPays HSA 	<ul style="list-style-type: none"> Balance HealthPays HSA
NETWORK	Group Health	Alliant Plus
MEDICAL GROUP	<p>IN-NETWORK: Group Health Physicians, plus thousands of contracted community providers</p> <p>OUT-OF-NETWORK: Not available</p>	<p>IN-NETWORK: Group Health Physicians, Virginia Mason, The Everett Clinic</p> <p>OUT-OF-NETWORK: Any doctor in the U.S., plus discounted rates from First Choice or Beech Street networks</p>

Physician groups

There are many physicians available to you regardless of the plan you pick, including the award-winning* doctors that make up Group Health Physicians (who are not available with any other health plan carrier). The chart below explains the medical groups and which networks give you access to each.

*The American Medical Group Association (AMGA) unanimously selected Group Health Physicians for the prestigious AMGA Acclaim Award, recognizing years of care excellence and innovative work and improvement. September 2010



The Balance plans



If choice is first and foremost, the Balance plans are for you 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.

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 preventive care office visits, and to most in-network office visits, which is a whole lot of value.

BALANCE 1750 PLAN - '11

	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA[‡] Nonsmoker	\$141	\$246	\$299	\$312	\$288	\$302	\$345	\$425	\$507	\$655	\$655
WWA Smoker	\$141	\$295	\$358	\$372	\$346	\$361	\$412	\$510	\$610	\$786	\$786
CENTRAL/EWA[‡] Nonsmoker	\$144	\$251	\$305	\$317	\$295	\$308	\$351	\$435	\$519	\$672	\$672
CENTRAL/EWA Smoker	\$144	\$302	\$366	\$383	\$354	\$369	\$423	\$523	\$624	\$802	\$802

BALANCE 2500 CATASTROPHIC PLAN - '11

	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA[‡] Nonsmoker	\$79	\$100	\$110	\$123	\$135	\$164	\$194	\$234	\$286	\$363	\$363
WWA Smoker	\$79	\$122	\$134	\$146	\$161	\$199	\$234	\$279	\$343	\$435	\$435
CENTRAL/EWA[‡] Nonsmoker	\$81	\$102	\$113	\$124	\$137	\$166	\$200	\$238	\$291	\$373	\$373
CENTRAL/EWA Smoker	\$81	\$124	\$136	\$149	\$165	\$202	\$238	\$286	\$351	\$448	\$448

BALANCE 5000 CATASTROPHIC PLAN - '11

	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA[‡] Nonsmoker	\$64	\$83	\$89	\$97	\$108	\$132	\$155	\$187	\$231	\$293	\$293
WWA Smoker	\$64	\$97	\$107	\$119	\$130	\$159	\$187	\$227	\$276	\$351	\$351
CENTRAL/EWA[‡] Nonsmoker	\$66	\$84	\$91	\$100	\$110	\$134	\$159	\$193	\$237	\$301	\$301
CENTRAL/EWA Smoker	\$66	\$98	\$109	\$120	\$133	\$161	\$193	\$230	\$282	\$361	\$361

[‡] 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. Rates effective July 1, 2011 - June 30, 2012. Rates based on age as of July 1, 2011.

COVERAGE	BALANCE 1750		BALANCE 2500		BALANCE 5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$1,750 per member or \$5,250 per family		\$2,500 per member or \$7,500 per family		\$5,000 per member or \$15,000 per family	
MEMBER COINSURANCE	20%	40%	40%	40%	50%	50%
OUT-OF-POCKET LIMIT[†] Deductible does not apply	\$6,000 per member or \$18,000 per family		\$8,000 per member or \$24,000 per family		\$10,000 per member or \$30,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS	Primary: \$30/visit Specialty: \$50/visit	Primary: \$30 + 40% Specialty: \$50 + 40%	Primary: \$30/visit Specialty: \$50/visit	Primary: \$30 + 40% Specialty: \$50 + 40%	Primary: \$30/visit Specialty: \$50/visit	Primary: \$30 + 50% Specialty: \$50 + 50%
MANIPULATIVE THERAPY Limit total visits PCY [†] to 10 combined for both in- and out-of-network.	\$30/visit	\$30/visit + 40%	\$30/visit	\$30/visit + 40%	\$30/visit	\$30/visit + 50%
ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit + 40%	\$30/visit, up to 8 visits PCY	\$30/visit + 40%	\$30/visit, up to 8 visits PCY	\$30/visit + 50%
NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit + 40%	\$30/visit, up to 3 visits PCY	\$30/visit + 40%	\$30/visit, up to 3 visits PCY	\$30/visit + 50%
MATERNITY CARE Outpatient non-routine prenatal and postpartum visits. Copay waived for routine care.	\$30/visit	\$30/visit + 40%	Not covered	Not covered	Not covered	Not covered
	AFTER DEDUCTIBLE, MEMBER PAYS		AFTER DEDUCTIBLE, MEMBER PAYS		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.	\$300 per day up to 5 days/admit + 20%	\$300 per day up to 5 days/admit + 40%	\$100 per day up to 5 days/admit + 40%	\$100 per day up to 5 days/admit + 40%	\$100 per day up to 5 days/admit + 50%	\$100 per day up to 5 days/admit + 50%
LAB/X-RAY SERVICES	Deductible waived on first \$400 PCY, then deductible and 20% apply.	40%	Deductible waived on first \$200 PCY, then deductible and 40% apply.	40%	Deductible waived on first \$200 PCY, then deductible and 50% apply.	50%
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)		Covered at 50%	Covered at 50%	Covered at 50%	Covered at 50%
EMERGENCY CARE	\$100 + 20%	\$100 + 20%	\$100 + 40%	\$100 + 40%	\$100 + 50%	\$100 + 50%
	DEDUCTIBLE DOES NOT APPLY		DEDUCTIBLE DOES NOT APPLY		DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule.	Covered in full	\$30/visit + 40% \$300 individual/ \$600 family annual benefit maximum	Covered in full	\$30/visit + 40% \$300 individual/ \$600 family annual benefit maximum	Covered in full	\$30/visit + 50% \$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. Mail order: \$5 discount for 30-day supply	\$15 generic/ 40% brand-name, 50% nonformulary	\$20 generic/ 40% brand-name, 50% nonformulary	Not covered	Not covered	Not covered	Not covered
VISION CARE	\$30 for routine eye exam per 12 months \$200 hardware benefit per 12 months. Not subject to coinsurance or deductible.	Covered up to \$30 for routine eye exam per 12 months	\$30 for routine eye exam per 12 months	Covered up to \$30 for routine eye exam per 12 months	\$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. No other fees for covered services apply to out-of-pocket limit.

[†] PCY = per calendar year

CARRYOVER: there is no 4th quarter deductible carryover.

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. 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.

The Welcome plans



Coverage with the Welcome plans runs the gamut. You can opt for more coverage if you think you're going to use your health care often, or you can choose a plan with a higher deductible that offers simple catastrophic coverage if you don't think you'll need it. Thinking about how you use your health care now will help you figure out which plan is right for you.

WELCOME 750 PLAN - '11											
	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA [‡] Nonsmoker	\$148	\$244	\$264	\$307	\$288	\$301	\$344	\$425	\$507	\$653	\$653
WWA Smoker	\$148	\$295	\$319	\$370	\$346	\$360	\$413	\$509	\$607	\$783	\$783
CENTRAL/EWA [‡] Nonsmoker	\$151	\$251	\$292	\$317	\$295	\$307	\$351	\$435	\$517	\$670	\$670
CENTRAL/EWA Smoker	\$151	\$301	\$351	\$380	\$352	\$369	\$422	\$521	\$621	\$802	\$802

WELCOME 2000 CATASTROPHIC PLAN - '11											
	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA [‡] Nonsmoker	\$72	\$89	\$99	\$108	\$118	\$145	\$169	\$205	\$251	\$322	\$322
WWA Smoker	\$72	\$106	\$117	\$129	\$142	\$173	\$204	\$247	\$303	\$385	\$385
CENTRAL/EWA [‡] Nonsmoker	\$74	\$90	\$101	\$110	\$120	\$147	\$174	\$210	\$258	\$328	\$328
CENTRAL/EWA Smoker	\$74	\$109	\$119	\$131	\$146	\$178	\$208	\$251	\$310	\$393	\$393

WELCOME 3500 CATASTROPHIC PLAN - '11											
	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA [‡] Nonsmoker	\$61	\$76	\$83	\$90	\$100	\$121	\$144	\$172	\$213	\$269	\$269
WWA Smoker	\$61	\$90	\$97	\$107	\$119	\$146	\$172	\$208	\$255	\$323	\$323
CENTRAL/EWA [‡] Nonsmoker	\$62	\$77	\$84	\$92	\$102	\$123	\$147	\$176	\$217	\$276	\$276
CENTRAL/EWA Smoker	\$62	\$92	\$101	\$110	\$121	\$150	\$176	\$212	\$262	\$331	\$331

[‡] 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. Rates effective July 1, 2011 - June 30, 2012. Rates based on age as of July 1, 2011.

	WELCOME 750	WELCOME 2000	WELCOME 3500
COVERAGE	GROUP HEALTH NETWORK	GROUP HEALTH NETWORK	GROUP HEALTH NETWORK
ANNUAL DEDUCTIBLE	\$750 per member or \$2,250 per family	\$2,000 per member or \$6,000 per family	\$3,500 per member or \$10,500 per family
MEMBER COINSURANCE	20%	40%	50%
OUT-OF-POCKET LIMIT [†] Deductible does not apply	\$4,000 per member or \$12,000 per family	\$6,000 per member or \$18,000 per family	\$10,000 per member or \$30,000 per family
BENEFITS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS
	First 4 visits: You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until after the 4th visit for services indicated by ■	First 4 visits: You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until after the 4th visit for services indicated by ■	First 4 visits: You pay only your copayment for your primary or specialty care visits. Your deductible and coinsurance do not apply until after the 4th visit for services indicated by ■
OFFICE VISITS	■ \$30 + 20% Primary care ■ \$50 + 20% Specialty care	■ \$30 + 40% Primary care ■ \$50 + 40% Specialty care	■ \$30 + 50% Primary care ■ \$50 + 50% Specialty care
PREVENTIVE CARE VISITS For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule.	Covered in full, deductible waived	Covered in full, deductible waived	Covered in full, deductible waived
MANIPULATIVE THERAPY	■ \$30 + 20%, up to 10 visits PCY [†]	■ \$30 + 40%, up to 10 visits PCY [†]	■ \$30 + 50%, up to 10 visits PCY [†]
ACUPUNCTURE	■ \$30 + 20%, up to 8 visits PCY	■ \$30 + 40%, up to 8 visits PCY	■ \$30 + 50%, up to 8 visits PCY
NATUROPATHY	■ \$30 + 20%, up to 3 visits PCY	■ \$30 + 40%, up to 3 visits PCY	■ \$30 + 50%, up to 3 visits PCY
MATERNITY CARE Outpatient non-routine prenatal and postpartum visits. Copay waived for routine care.	■ \$30 + 20% Delivery & associated hospital care: \$500 per day to 5 days/admit + 20%	Not covered	Not covered
LAB/X-RAY SERVICES	Deductible waived on first \$400 PCY, then deductible and 20% apply.	Deductible waived on first \$200 PCY, then deductible and 40% apply.	Deductible waived on first \$200 PCY, then deductible and 50% apply.
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.	\$500 per day to 5 days/admit + 20%	40%	50%
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)	50%	50%
PRESCRIPTION DRUGS – OUTPATIENT Drugs and medicines that require prescription, including self-administered injectables, contraceptive drugs, devices, and supplies.	\$15 copay generic/30% brand-name \$3,000 annual benefit maximum Not subject to deductible Mail order: \$5 discount for 30-day supply	Not covered	Not covered
EMERGENCY CARE Group Health or Group Health-designated facilities. Non-Group Health or non-Group Health-designated facilities worldwide, including urgent care facilities.	\$100 + 20% \$100 + 20%	\$100 + 40% \$100 + 40%	\$100 + 50% \$100 + 50%
VISION CARE \$200 hardware benefit per 12 month period. Hardware not subject to deductible or coinsurance.	■ \$30 + 20% for routine eye exam	■ \$30 + 40% for routine eye exam	■ \$30 + 50% for routine eye exam

+ Member coinsurance and emergency care copayment apply. No other fees for covered services apply to out-of-pocket limit.

[†] PCY = per calendar year

CARRYOVER: there is no 4th quarter deductible carryover.

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. 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.

The HealthPays® HSA plans



THERE ARE TWO HEALTHPAYS HEALTH SAVINGS ACCOUNT PLANS FOR YOU TO CHOOSE FROM:

One that gives you the Group Health in-network option, and one that gives you the Alliant Plus in- and out-of network options. Either way, you can pair your plan with a separate savings account designated for pretax money that you can use to pay eligible medical expenses.

You can choose your own financial institution or choose to use our partner - HealthEquity®. HealthEquity is one of the nation's oldest and largest dedicated savings account trustees—providing account administration support, live daily claims updates, online tools, and a 24/7 call center whenever help is needed. Contact www.healthequity.com or 877-291-1936. Either way, you can be sure your money is safe.

THERE ARE A FEW ELIGIBILITY RULES: You can't be covered under another plan or enrolled in Medicare, and children under the age of 18 may enroll but won't be eligible for an associated savings account. 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.

For more information about health savings accounts, contact your tax or legal advisors.

HEALTHPAYS 2000/4000 HSA - GROUP HEALTH HEALTHPAYS 2750/5500 HSA - ALLIANT PLUS

COVERAGE	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$2,000 per member or \$4,000 per family	\$2,750 per member or \$5,500 per family	
MEMBER COINSURANCE	20%	20%	40%
OUT-OF-POCKET LIMIT†	\$5,100 per member or \$10,200 per family	\$5,100 per member or \$10,200 per family	
BENEFITS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS Includes mental health outpatient services.	20%	20%	40%
MANIPULATIVE THERAPY Limit total visits PCY† to 10 combined for both in- and out-of-network.	20%	20%	40%
ACUPUNCTURE	20%, up to 8 visits PCY	20%, up to 8 visits PCY	40%
NATUROPATHY	20%, up to 3 visits PCY	20%, up to 3 visits PCY	40%
MATERNITY CARE	Not covered	Not covered	Not covered
LAB/X-RAY SERVICES	20%	20%	40%
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.	20%	20%	40%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	Covered at 50%	Covered at 50%	Covered at 50%
PRESCRIPTION DRUGS	Not covered	Not covered	Not covered
EMERGENCY CARE	20%	20%	20%
VISION CARE	Not covered	Not covered	Not covered
	DEDUCTIBLE DOES NOT APPLY	DEDUCTIBLE DOES NOT APPLY	
PREVENTIVE CARE VISITS For children and adults, including physicals and immunizations, as established in Group Health's well-care schedule.	Covered in full	Covered in full	40% \$300 individual/ \$600 family annual benefit maximum

+ All fees for covered services apply to out-of-pocket limit.

† PCY = per calendar year

CARRYOVER: there is no 4th quarter deductible carryover.

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. 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 and Group Health Options, Inc.

GROUP HEALTH | HSA 2000 INDIVIDUAL/4000 FAMILY CATASTROPHIC PLAN - '11

	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA‡ Nonsmoker	\$75	\$91	\$100	\$108	\$120	\$147	\$173	\$207	\$256	\$323	\$323
WWA Smoker	\$75	\$108	\$118	\$130	\$145	\$176	\$207	\$249	\$307	\$389	\$389
CENTRAL/EWA‡ Nonsmoker	\$77	\$92	\$102	\$110	\$122	\$149	\$178	\$212	\$263	\$329	\$329
CENTRAL/EWA Smoker	\$77	\$111	\$120	\$132	\$149	\$181	\$211	\$253	\$314	\$397	\$397

ALLIANT PLUS | HSA 2750 INDIVIDUAL/5500 FAMILY CATASTROPHIC PLAN - '11

	Dep. child under 26	Adult age 24 & under	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
WWA‡ Nonsmoker	\$77	\$97	\$106	\$117	\$129	\$157	\$187	\$224	\$277	\$350	\$350
WWA Smoker	\$77	\$117	\$128	\$140	\$155	\$189	\$224	\$269	\$331	\$419	\$419
CENTRAL/EWA‡ Nonsmoker	\$79	\$98	\$111	\$119	\$133	\$161	\$191	\$230	\$282	\$358	\$358
CENTRAL/EWA Smoker	\$79	\$119	\$130	\$143	\$160	\$193	\$229	\$274	\$338	\$429	\$429

‡ 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. Rates effective July 1, 2011 - June 30, 2012. Rates based on age as of July 1, 2011.

Primary and specialty care

About your cost shares

Each of our individual and family plans gives you access to great doctors, especially when you get care from doctors who practice with Group Health Physicians. With that in mind, the Welcome and Balance plans are designed with a lower copayment for the type of care that's needed most often—primary care. The list here explains the types of care that you'll pay a lower copay for, and the ones for which you'll pay a higher copay—regardless of where you get your care.

PRIMARY CARE | LOWER COST SHARE

Acupuncture	General Practice	Occupational Therapy
Audiology	Health Education	Optometry
Chemical Dependency/ Substance Abuse	Internal Medicine	Osteopathy
Chiropractic	Massage Therapy	Pediatrics
Emergency Medicine <small>(where ER copay doesn't apply)</small>	Mental Health	Physical Therapy
Enterostomal Therapy	Midwifery	Respiratory Therapy
Family Planning	Naturopathy	Speech Therapy
Family Practice	Nutrition	Urgent Care
	Obstetrics & Gynecology	Women's Health Care
	Occupational Medicine	

SPECIALTY CARE | HIGHER COST SHARE

Allergy & Immunology	Hepatology	Physiatry <small>(Physical Medicine)</small>
Anesthesiology	Infectious Disease	Podiatry
Cardiology <small>(Pediatric & cardiovascular disease)</small>	Neonatal-Perinatal Medicine	Pulmonary Medicine/Disease
Critical Care Medicine	Nephrology	Radiology <small>(Nuclear Medicine, Radiation Therapy)</small>
Dentistry	Neurology	Rheumatology
Dermatology	Hematology/Oncology	Sports Medicine
Endocrinology	Ophthalmology	General Surgery <small>(all specific surgeries)</small>
Gastroenterology	Orthopedics	Urology
Genetics	ENT/Otolaryngology	
	Pathology	

Optional dental

OPTIONAL 2011 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)



MONTHLY RATES

Subscriber	\$50.96
Subscriber and child(ren) ⁺	\$89.96
Subscriber and spouse	\$96.20
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 prescriptions 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.

† \$150 per family calendar year deductible.

* Group Health refers to Group Health Cooperative or Group Health Options, Inc.

+ Children under 3 are not required to enroll.

Yes, here's the fine print—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.

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 will help as you look through this summary, and other communication you might receive from us.

AGE BAND

An age band is a range of ages. Each of our plans has rates that differ by age band. Your rate is based on your age as of July 1. As your plan renews, your age band might change from one year to the next. For example, if you are 39 when you enroll this year you'll fall in the 35–39 age band and will pay the premium associated with that age band for the plan you choose. The following year, at the July 1 renewal, you'd move to the 40–44 age band and pay the rate associated with your new age band.

COINSURANCE

This is the percentage amount you pay for 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. 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.

ESSENTIAL HEALTH BENEFITS

Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

IN-NETWORK

This is care you receive from the more than 1,000 providers at more than two dozen Group Health Medical Centers locations, or from thousands of contracted community providers. And, for the Balance Plans and the Group Health Options HealthPays plan, 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.

MEDICARE

Benefits provided by the Federal government for individuals over the age of 65, individuals under 65 who have been on disability for 24 consecutive months, or any individual with ESRD (end stage renal disease).

OUT-OF-NETWORK

This includes all doctors who do not work directly for Group Health or who are not contracted with Group Health to provide in-network care. For the Balance and Group Health Options HealthPays HSA plans, you can see any doctor you want, anywhere in the U.S. Your coverage level will be slightly less than if you receive care in-network. The Welcome and the Group Health Cooperative HealthPays HSA plans do not have an out-of-network option.

OUT-OF-POCKET LIMIT

This is the maximum you pay for certain covered services in a calendar year. Notice that each plan has different limits and only certain fees apply.

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
1-800-358-8815

Remember, this is just a summary, so if you need more information or just another definition, give individual and family sales a call. Our representatives are ready to answer your questions.