

WELCOME 1750

A HAPPY MEDIUM.

The Welcome 1750 Catastrophic Plan—'09 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, 2009–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON[‡] WELCOME \$1750

	NON-SMOKER	SMOKER
Dependent child under 25*	\$71	\$71
Adult age 24 or under	\$84	\$99
25 - 29	\$92	\$110
30 - 34	\$101	\$121
35 - 39	\$111	\$133
40 - 44	\$136	\$162
45 - 49	\$159	\$191
50 - 54	\$192	\$231
55 - 59	\$236	\$284
60 - 64	\$301	\$360
65 +	\$301	\$360

CENTRAL/EASTERN WASHINGTON[‡] WELCOME \$1750

	NON-SMOKER	SMOKER
Dependent child under 25*	\$73	\$73
Adult age 24 or under	\$85	\$102
25 - 29	\$94	\$112
30 - 34	\$103	\$123
35 - 39	\$113	\$137
40 - 44	\$138	\$166
45 - 49	\$163	\$195
50 - 54	\$197	\$235
55 - 59	\$242	\$290
60 - 64	\$307	\$368
65 +	\$307	\$368

GROUP HEALTH NETWORK

ANNUAL DEDUCTIBLE \$1,750 per member or \$5,250 per family

MEMBER COINSURANCE 40%

OUT-OF-POCKET LIMIT** \$6,000 per member or \$18,000 per family
(Deductible does not apply.)

BENEFITS AFTER DEDUCTIBLE, MEMBER PAYS

First 5 visits: You pay 40% coinsurance. Your deductible does not apply until **after** the 5th visit for services indicated by ■

OFFICE VISITS ■ 40%
Includes urgent care.

PREVENTIVE CARE ■ 40%
For children and adults, including physicals and immunizations, as established in Group Health's preventive care schedule.

MANIPULATIVE THERAPY ■ 40%, up to 10 visits PCY[†]

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 40%
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 + 40%
Non-Group Health or non-Group Health–designated facilities worldwide. \$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.

‡ 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.

† 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-'09 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, 2009–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON[‡] WELCOME \$3500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$59	\$59
Adult age 24 or under	\$69	\$82
25 - 29	\$76	\$90
30 - 34	\$82	\$99
35 - 39	\$92	\$110
40 - 44	\$112	\$133
45 - 49	\$131	\$158
50 - 54	\$158	\$190
55 - 59	\$195	\$234
60 - 64	\$247	\$297
65 +	\$247	\$297

CENTRAL/EASTERN WASHINGTON[‡] WELCOME \$3500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$60	\$60
Adult age 24 or under	\$70	\$84
25 - 29	\$77	\$93
30 - 34	\$85	\$102
35 - 39	\$94	\$112
40 - 44	\$114	\$137
45 - 49	\$134	\$162
50 - 54	\$162	\$194
55 - 59	\$200	\$240
60 - 64	\$253	\$304
65 +	\$253	\$304

GROUP HEALTH NETWORK

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

MEMBER COINSURANCE 50%

OUT-OF-POCKET LIMIT** \$10,000 per member or \$30,000 per family
(Deductible does not apply.)

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[†]

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.

‡ 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.

† PCY = per calendar year

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Coverage provided by Group Health Cooperative.

BALANCE 2500

COVERAGE WHEN YOU NEED IT.

The Balance 2500 Catastrophic Plan—09 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, 2009–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON[‡] BALANCE \$2500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$60	\$60
Adult age 24 or under	\$70	\$84
25 - 29	\$77	\$93
30 - 34	\$85	\$102
35 - 39	\$94	\$112
40 - 44	\$114	\$137
45 - 49	\$134	\$162
50 - 54	\$162	\$194
55 - 59	\$199	\$238
60 - 64	\$253	\$303
65 +	\$253	\$303

CENTRAL/EASTERN WASHINGTON[‡] BALANCE \$2500

	NON-SMOKER	SMOKER
Dependent child under 25*	\$62	\$62
Adult age 24 or under	\$71	\$86
25 - 29	\$79	\$95
30 - 34	\$86	\$104
35 - 39	\$96	\$115
40 - 44	\$116	\$140
45 - 49	\$138	\$165
50 - 54	\$165	\$199
55 - 59	\$203	\$244
60 - 64	\$259	\$311
65 +	\$259	\$311

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$2,500 per member or \$7,500 per family	
MEMBER COINSURANCE	40%	40%
OUT-OF-POCKET LIMIT⁺ (Deductible does not apply.)	\$8,000 per member or \$24,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS	\$30/visit	\$30/visit
MANIPULATIVE THERAPY Limit total visits PCY [†] to 10 combined for both in- and out-of-network.	\$30/visit	\$30/visit
ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit
NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit
MATERNITY CARE	Not covered	Not covered
MENTAL HEALTH SERVICES Outpatient: 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	
MENTAL HEALTH SERVICES Inpatient: Limit total days PCY to 12 combined for both in- and out-of-network.	40%	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%	40%
EMERGENCY CARE	\$100 + 40%	\$150 + 40%
	DEDUCTIBLE DOES NOT APPLY	
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	Not covered	Not covered
VISION CARE Hardware not covered.	\$30 for routine eye exam per 12 months	Covered up to \$30 for routine eye exam per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.

† PCY = per calendar year

‡ Western Washington counties: King, Kitsap, Pierce, Snohomish, Island, Thurston, Whatcom, Skagit, San Juan, Mason, Lewis, and Gray's Harbor (ZIP codes: 98541, 98557, 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-'09 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, 2009–June 30, 2010.
Rates based on age as of July 1, 2009.

WESTERN WASHINGTON[‡] BALANCE \$5000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$51	\$51
Adult age 24 or under	\$59	\$70
25 - 29	\$64	\$77
30 - 34	\$70	\$85
35 - 39	\$78	\$94
40 - 44	\$95	\$114
45 - 49	\$112	\$134
50 - 54	\$134	\$162
55 - 59	\$166	\$199
60 - 64	\$210	\$253
65 +	\$210	\$253

CENTRAL/EASTERN WASHINGTON[‡] BALANCE \$5000

	NON-SMOKER	SMOKER
Dependent child under 25*	\$52	\$52
Adult age 24 or under	\$60	\$71
25 - 29	\$66	\$79
30 - 34	\$72	\$86
35 - 39	\$80	\$96
40 - 44	\$97	\$116
45 - 49	\$114	\$138
50 - 54	\$138	\$165
55 - 59	\$170	\$203
60 - 64	\$216	\$259
65 +	\$216	\$259

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$5,000 per member or \$15,000 per family	
MEMBER COINSURANCE	50%	50%
OUT-OF-POCKET LIMIT[†] (Deductible does not apply.)	\$10,000 per member or \$30,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS	\$30/visit	\$30/visit
MANIPULATIVE THERAPY Limit total visits PCY [†] to 10 combined for both in- and out-of-network.	\$30/visit	\$30/visit
ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit
NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit
MATERNITY CARE	Not covered	Not covered
MENTAL HEALTH SERVICES Outpatient: 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	
MENTAL HEALTH SERVICES Inpatient: Limit total days PCY to 12 combined for both in- and out-of-network.	50%	50%
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.	50%	50%
EMERGENCY CARE	\$100 + 50%	\$150 + 50%
	DEDUCTIBLE DOES NOT APPLY	
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	Not covered	Not covered
VISION CARE Hardware not covered.	\$30 for routine eye exam per 12 months	Covered up to \$30 for routine eye exam per 12 months

+ Member coinsurance and emergency care copayment apply to out-of-pocket limit.

† PCY = per calendar year

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