

# BALANCE 1000

## THE MOST COVERAGE.

The Balance 1000 Plan-'09 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, 2009–June 30, 2010.  
Rates based on age as of July 1, 2009.

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$128	\$128
Adult age 24 or under	\$203	\$244
25 - 29	\$246	\$296
30 - 34	\$258	\$308
35 - 39	\$238	\$286
40 - 44	\$249	\$298
45 - 49	\$284	\$341
50 - 54	\$351	\$423
55 - 59	\$419	\$503
60 - 64	\$541	\$650
65 +	\$541	\$650

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$130	\$130
Adult age 24 or under	\$208	\$250
25 - 29	\$252	\$303
30 - 34	\$263	\$315
35 - 39	\$244	\$293
40 - 44	\$254	\$305
45 - 49	\$290	\$349
50 - 54	\$360	\$432
55 - 59	\$429	\$515
60 - 64	\$554	\$664
65 +	\$554	\$664

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
--	----------------------------	--------------------------------

ANNUAL DEDUCTIBLE	\$1,000 per member or \$3,000 per family	
MEMBER COINSURANCE	20%	20%
OUT-OF-POCKET LIMIT <sup>†</sup> (Deductible does not apply.)	\$4,000 per member or \$12,000 per family	

BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
----------	---------------	----------------------------------

OFFICE VISITS	\$30/visit	\$30/visit
MANIPULATIVE THERAPY Limit total visits PCY <sup>†</sup> 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 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
-------------------------------

MATERNITY CARE Delivery & associated hospital care.	20%	20%
MENTAL HEALTH SERVICES <b>Inpatient:</b> Limit total days PCY to 12 combined for both in- and out-of-network.	20%	20%
HOSPITAL VISITS – INPATIENT Hospital room and board; inpatient surgery; anesthesia, intensive and coronary care; laboratory tests; radiology services; drugs while in hospital.	20%	20%
EMERGENCY CARE	\$100 + 20%	\$150 + 20%

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 <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. <b>Mail order:</b> \$5 discount for 30-day supply	\$10 generic/30% brand name 50% non-formulary	\$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 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.

**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.

203IF 05-09W

# BALANCE 1500

## LOTS OF COVERAGE.

The Balance 1500 Plan-'09 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. And 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, 2009–June 30, 2010.  
Rates based on age as of July 1, 2009.

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$107	\$107
Adult age 24 or under	\$172	\$206
25 - 29	\$208	\$250
30 - 34	\$217	\$260
35 - 39	\$201	\$241
40 - 44	\$210	\$252
45 - 49	\$240	\$288
50 - 54	\$297	\$356
55 - 59	\$354	\$425
60 - 64	\$457	\$548
65 +	\$457	\$548

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$110	\$110
Adult age 24 or under	\$175	\$210
25 - 29	\$212	\$255
30 - 34	\$221	\$267
35 - 39	\$206	\$246
40 - 44	\$215	\$258
45 - 49	\$245	\$295
50 - 54	\$304	\$365
55 - 59	\$363	\$435
60 - 64	\$468	\$560
65 +	\$468	\$560

	ALLIANT PLUS IN-NETWORK	ALLIANT PLUS OUT-OF-NETWORK
--	-------------------------	-----------------------------

ANNUAL DEDUCTIBLE	\$1,500 per member or \$4,500 per family	
MEMBER COINSURANCE	30%	30%
OUT-OF-POCKET LIMIT <sup>+</sup> (Deductible does not apply.)	\$6,000 per member or \$18,000 per family	

BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
----------	---------------	-------------------------------

OFFICE VISITS	\$30/visit	\$30/visit
MANIPULATIVE THERAPY Limit total visits PCY <sup>†</sup> 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 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
-------------------------------

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
---------------------------

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. <b>Mail order:</b> \$5 discount for 30-day supply	\$10 generic/30% brand name 50% non-formulary	\$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 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.

**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.

204IF 05-09W

# WELCOME 500

## THE MOST COVERAGE.

The Welcome 500 Plan-'09 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, 2009–June 30, 2010.  
Rates based on age as of July 1, 2009.

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$148	\$148
Adult age 24 or under	\$235	\$283
25 - 29	\$255	\$307
30 - 34	\$296	\$356
35 - 39	\$277	\$332
40 - 44	\$289	\$347
45 - 49	\$330	\$396
50 - 54	\$408	\$490
55 - 59	\$487	\$584
60 - 64	\$628	\$754
65 +	\$628	\$754

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

	NON-SMOKER	SMOKER
Dependent child under 25*	\$151	\$151
Adult age 24 or under	\$241	\$289
25 - 29	\$281	\$338
30 - 34	\$305	\$366
35 - 39	\$283	\$339
40 - 44	\$296	\$355
45 - 49	\$338	\$405
50 - 54	\$418	\$502
55 - 59	\$498	\$598
60 - 64	\$643	\$772
65 +	\$643	\$772

## GROUP HEALTH NETWORK

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

**MEMBER COINSURANCE** 20%

**OUT-OF-POCKET LIMIT\*\*** \$4,000 per member or \$12,000 per family  
(Deductible does not apply.)

## 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.  
Non-Group Health or non-Group Health–designated facilities worldwide. \$150 + 20%

**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.

‡ 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.