

Balance 1750 - 11

Rates effective February 1, 2012 - June 30, 2012



If broad choice is important look at the Balance plans. They come with access to any doctor for primary, specialty, and alternative care in the U.S., and the choice between in-network and out-of-network care (with different levels of coverage). These plans are structured like traditional copayment plans, and the deductible doesn't apply to preventive care office visits and most in-network office visits.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	\$1,750 per member or \$5,250 per family	
MEMBER COINSURANCE	20%	40%
OUT-OF-POCKET LIMIT* Deductible does not apply	\$6,000 per member or \$18,000 per family	
BENEFITS	NO DEDUCTIBLE	AFTER DEDUCTIBLE, MEMBER PAYS
OFFICE VISITS	Primary: \$30/visit Specialty: \$50/visit	Primary: \$30 + 40% Specialty: \$50 + 40%
MANIPULATIVE THERAPY Limit total visits PCY to 10 combined for both in- and out-of-network.	\$30/visit	\$30/visit + 40%
ACUPUNCTURE	\$30/visit, up to 8 visits PCY	\$30/visit + 40%
NATUROPATHY	\$30/visit, up to 3 visits PCY	\$30/visit + 40%
MATERNITY CARE Outpatient non-routine prenatal and postpartum visits. Copay waived for routine care.	\$30/visit	\$30/visit + 40%
	Delivery & associated care covered at hospital inpatient cost share.	
	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%
LAB/X-RAY SERVICES	Deductible waived on first \$400 PCY, then deductible and 20% apply.	40%
DEVICES, EQUIPMENT & SUPPLIES (DME and prosthetics)	DME—50% Prosthetics—50%	
EMERGENCY CARE	\$100 + 20%	\$100 + 20%
	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
PRESCRIPTION DRUGS Outpatient: Drugs and medicines that require prescription, including self-administered injectables, contraceptive drugs, devices, and supplies.	\$15 generic/40% brand-name, 50% nonformulary Mail order: \$5 discount for 30-day supply	\$20 generic/40% brand-name, 50% nonformulary
VISION CARE	\$30 for routine eye exam per 12 months	Covered up to \$30 for routine eye exam per 12 months
	\$200 hardware benefit per 12 months. Not subject to coinsurance or deductible.	

+ Member coinsurance and emergency care copayment apply. No other fees for covered services apply to 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, 98559, & 98568). Central/Eastern Washington counties: Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Whitman, and Spokane. Rates based on age as of July 1, 2011.

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.

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	\$147	\$256	\$311	\$325	\$300	\$314	\$359	\$442	\$528	\$682	\$682
WWA Smoker	\$147	\$307	\$373	\$387	\$360	\$376	\$429	\$531	\$635	\$818	\$818
CENTRAL/EWA[‡] Nonsmoker	\$150	\$261	\$318	\$330	\$307	\$321	\$365	\$453	\$540	\$700	\$700
CENTRAL/EWA Smoker	\$150	\$314	\$381	\$399	\$369	\$384	\$440	\$544	\$650	\$835	\$835