



Individual Health Insurance Benefits & Rates Comparison for Prospective Client

Applicant: your age, nonsmoker/smoker - Spouse: your spouse's age, nonsmoker/smoker - Number of Children: your number of children, if any

Plans in Your Customized Comparison Will Be Shown in Order of Least to Most Expensive

Monthly Rates Valid for Effective Dates of May 1 to June 1, 2007 (please see "Notes Regarding Rates" on page 11)





Plan ID #	Monthly Rate	Carrier	Plan Name	Plan Type	Annual Deductible (per person/limit per family)	Network Benefit (Coinsurance)	Coinsurance Maximum (per person/limit per family) excluding deductible	Office Visit Copay	Maternity	Prescription (Rx) Drug Benefit	Preventive Care Benefit	Vision Exam & Hardware
1	\$0.00		Home Choice \$350 (this plan is available only for residents of Kitsap, Mason, Jefferson & Clallam counties)	PPO	Home Choice Network: \$350 / \$1,050 (no deductible for 1st 3 office visits per year) Participating Network: \$700 / \$2,100	Home Choice Network: 80% (100% for 1st 3 office visits per year) Participating Network: 60%	Home Choice Network: \$3,500 / \$10,500 Participating Network: \$7,000 / \$21,000	Home Choice Network: \$20 Participating Network: \$0	Covered	No deductible; you pay: \$5 (generic) or \$35 (preferred brand-name) or \$50% (non-preferred); \$2,000 max benefit per year	Home Choice Network: no deductible; 100% to \$350 max per year Participating Network: after deductible, 60% to \$350 max per year	One routine eye exam per year (included as part of Preventive Care Benefit); Lenses & frames: no deductible and paid at 100% to \$100 per year
2	\$0.00		Home Choice \$750 (this plan is available only for residents of Kitsap, Mason, Jefferson & Clallam counties)	PPO	Home Choice Network: \$750 / \$2,250 Participating Network: \$1,500 / \$3,000	Home Choice Network: 80% Participating Network: 60%	Home Choice Network: \$3,500 / \$10,500 Participating Network: \$7,000 / \$21,000	\$0	Covered	No deductible; you pay: \$5 (generic) or \$35 (preferred brand-name) or \$50% (non-preferred); \$2,000 max benefit per year	Home Choice Network: no deductible; 100% to \$350 max per year Participating Network: after deductible, 60% to \$350 max per year	One routine eye exam per year (included as part of Preventive Care Benefit); Lenses & frames: no deductible and paid at 100% to \$100 per year
3	\$0.00		Sound Harbor Classic Five	PPO	\$500 / \$1,500 (in addition to the deductible, this plan also includes a \$250 per day inpatient hospital copay; \$1,250 maximum copay per admission)	80%	\$5,000 / \$15,000	\$0	Covered	After the annual deductible is satisfied, you pay: \$5 (generic) \$35 (brand-name formulary) or 50% (non-formulary); \$2,000 max benefit per year	No deductible; 100% to \$250 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); lenses & frames paid at 80% to \$200 each 2 years after the annual deductible is satisfied
4	\$0.00		Sound Harbor Classic 50/50	PPO	\$700 / \$2,100 (in addition to the deductible, this plan also includes a \$250 per day inpatient hospital copay; \$1,250 maximum copay per admission)	50%	\$5,000 / \$15,000	\$0	Covered	After the annual deductible is satisfied, you pay: \$5 (generic) \$35 (brand-name formulary) or 50% (non-formulary); \$2,000 max benefit per year	No deductible; 100% to \$250 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); lenses & frames paid at 50% to \$125 each 2 years after the annual deductible is satisfied

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5	\$0.00		Sound Harbor Essential Five Option 1	PPO	\$1,500/ \$4,500	80%	\$6,000/ \$18,000	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	After deductible, 80% to \$200 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
6	\$0.00		Sound Harbor Essential Five Option 2	PPO	\$2,500/ \$7,500	80%	\$10,000/ \$30,000	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	After deductible, 80% to \$200 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
7	\$0.00		Sound Harbor Essential Five Option 3	PPO	\$5,000/ \$15,000	80%	\$20,000/ \$60,000	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	After deductible, 80% to \$200 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
8	\$0.00		The Healthy Investor Option 1 (with Rx drug) <u>HSA-qualified plan</u>	PPO	\$3,200 aggregate per family	80%	\$6,800 aggregate per family	\$0	Not covered	Prescriptions paid after deductible is satisfied; paid at 80% to \$2,000 maximum per person per calendar year	After deductible, 80% to \$300 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit







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9	\$0.00		The Healthy Investor Option 2 (with Rx drug) HSA-qualified plan	PPO	\$5,150 aggregate per family	80%	\$4,850 aggregate per family	\$0	Not covered	Prescriptions paid after deductible is satisfied; paid at 80% to \$2,000 maximum per person per calendar year	After deductible, 80% to \$300 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
10	\$0.00		The Healthy Investor Option 1 (no Rx drug) HSA-qualified plan	PPO	\$3,200 aggregate per family	80%	\$6,800 aggregate per family	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	After deductible, 80% to \$300 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
11	\$0.00		The Healthy Investor Option 2 (no Rx drug) HSA-qualified plan	PPO	\$5,150 aggregate per family	80%	\$4,850 aggregate per family	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	After deductible, 80% to \$300 maximum per year	One routine eye exam per year (included as part of Preventive Care benefit); no vision hardware benefit
12	\$0.00		Welcome 500	HMO	\$500/ \$1,500 (no deductible for 1st 4 office visits & 1st \$500 outpatient x-ray & lab per year)	80% (100% for 1st 4 office visits & 1st \$500 outpatient x-ray & lab per year)	\$2,000/ \$6,000 (in addition to the deductible, this plan also includes a \$500 per day inpatient hospital copay; \$2,500 maximum copay per admission)	\$30	Covered	No deductible; you pay: \$20 (generic) or \$40 (brand-name formulary); non-formulary not covered; \$3,000 max benefit per year	No deductible; covered same as an office visit; no maximum per year	One routine eye exam each 12 months; covered same as an office visit; vision hardware not subject to deductible and paid at 100% to \$200 each 12 months



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13	\$0.00		Welcome 1500	HMO	\$1,500/ \$4,500 <small>(no deductible for 1st 4 office visits per year)</small>	50%	\$4,000/ \$12,000	\$0	Not covered	Not covered	No deductible; covered same as an office visit; no maximum per year	One routine eye exam each 12 months; covered same as an office visit; vision hardware not subject to deductible and paid at 100% to \$200 each 12 months
14	\$0.00		Compass 500	HMO	\$500/ \$1,500	80%	\$2,000/ \$6,000	\$0	Covered	No deductible; you pay: \$20 (generic) or \$40 (brand-name formulary); non-formulary not covered; \$2,000 max benefit per year	No deductible; 80%; no maximum per year	One routine eye exam each 12 months paid at 80% after annual deductible is satisfied; no hardware benefit
15	\$0.00		Compass 1500	HMO	\$1,500/ \$4,500	80%	\$4,000/ \$12,000	\$0	Not covered	Not covered	No deductible; 80%; no maximum per year	One routine eye exam each 12 months paid at 80% after annual deductible is satisfied; no hardware benefit
16	\$0.00		Compass 2500	HMO	\$2,500/ \$7,500	50%	\$6,000/ \$18,000	\$0	Not covered	Not covered	No deductible; 50%; no maximum per year	Not covered



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17	\$0.00		Compass 5000	HMO	\$5,000/ \$15,000	70%	\$10,000/ \$30,000	\$0	Not covered	Not covered	No deductible; 70%; no maximum per year	One routine eye exam each 12 months paid at 70% after annual deductible is satisfied; no hardware benefit
18	\$0.00		HealthPays 3000 Family Plan HSA-qualified plan	HMO	\$3,000 aggregate per family	80%	\$7,200 aggregate per family	\$0	Not covered	Not covered	No deductible; 80%; no maximum per year	Not covered
19	\$0.00		HealthPays 5000 Family Plan HSA-qualified plan	HMO	\$5,000 aggregate per family	80%	\$5,200 aggregate per family	\$0	Not covered	Not covered	No deductible; 80%; no maximum per year	Not covered
20	\$0.00		WiseChoices 0/20	PPO	PPO: None Non-PPO: \$3,000/ \$9,000	100% for office visits 80% for other services	PPO: \$9,500/ \$28,500 Non-PPO: no maximum	\$30 (\$25 for spinal manipulations & acupuncture)	Covered	You pay: \$10 (generic); \$45 (preferred brand name) or 50% (non-preferred brand name) \$3,000 max benefit per year for brand name drugs; no maximum for generic drugs	PPO: exam paid at 100% after \$30 copay; immunizations & screenings (pap smear, PSA testing, cholesterol, etc.) at 100% without copay. Non-PPO: 50% (no immunizations). No maximum per year.	One routine eye exam paid at 100% each 2 years; frames, lenses & contact lenses paid at 100% to \$200 each 2 years

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21	\$0.00		WiseChoices 0/30	PPO	PPO: None Non-PPO: \$3,000/\$9,000	100% for office visits 70% for other services	PPO: \$9,500/\$28,500 Non-PPO: no maximum	\$30 (\$25 for spinal manipulations & acupuncture)	Covered	You pay: \$10 (generic); \$45 (preferred brand name) or 50% (non-preferred brand name) \$3,000 max benefit per year for brand name drugs; no maximum for generic drugs	PPO: exam paid at 100% after \$30 copay; immunizations & screenings (pap smear, PSA testing, cholesterol, etc.) at 100% without copay. Non-PPO: 50% (no immunizations). No maximum per year.	One routine eye exam paid at 100% each 2 years; frames, lenses & contact lenses paid at 100% to \$200 each 2 years
22	\$0.00		WiseChoices 20	PPO	PPO: \$1,000/\$3,000 (no deductible for office visits) Non-PPO: \$3,000/\$9,000	100% for office visits 80% for other services	PPO: \$8,500/\$25,500 Non-PPO: no maximum	\$30 (\$25 for spinal manipulations & acupuncture)	Covered	You pay: \$10 (generic); \$45 (preferred brand name) or 50% (non-preferred brand name) \$3,000 max benefit per year for brand name drugs; no maximum for generic drugs	PPO: exam paid at 100% after \$30 copay; immunizations & screenings (pap smear, PSA testing, cholesterol, etc.) at 100% without copay. Non-PPO: 50% (no immunizations). No maximum per year.	One routine eye exam paid at 100% each 2 years; frames, lenses & contact lenses paid at 100% to \$200 each 2 years
23	\$0.00		WiseChoices 30	PPO	PPO: \$1,500/\$4,500 (no deductible for office visits) Non-PPO: \$3,000/\$9,000	100% for office visits 70% for other services	PPO: \$8,500/\$25,500 Non-PPO: no maximum	\$30 (\$25 for spinal manipulations & acupuncture)	Covered	You pay: \$10 (generic); \$45 (preferred brand name) or 50% (non-preferred brand name) \$3,000 max benefit per year for brand name drugs; no maximum for generic drugs	PPO: exam paid at 100% after \$30 copay; immunizations & screenings (pap smear, PSA testing, cholesterol, etc.) at 100% without copay. Non-PPO: 50% (no immunizations). No maximum per year.	One routine eye exam paid at 100% each 2 years; frames, lenses & contact lenses paid at 100% to \$200 each 2 years
24	\$0.00		WiseEssentials 25 \$1,500 Deductible	PPO	PPO: \$1,500/no limit (no deductible for 1st 6 office visits per year and outpatient x-ray & lab) Non-PPO: \$3,000/no limit	75%	PPO: \$5,000/no family limit Non-PPO: no maximum	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	PPO: exam paid same as an office visit; screenings (pap smear, PSA testing, cholesterol, etc.) no deductible & paid at 100%. Non-PPO: 50%. Immunizations not covered. No maximum per year.	Not covered

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25	\$0.00		WiseEssentials 25 \$2,500 Deductible	PPO	PPO: \$2,500/no limit (no deductible for 1st 6 office visits per year) Non-PPO: \$5,000/no limit	75%	PPO: \$5,000/ no family limit Non-PPO: no maximum	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	PPO: exam paid same as an office visit; screenings (pap smear, PSA testing, cholesterol, etc.) no deductible & paid at 100%. Non-PPO: 50%. Immunizations not covered. No maximum per year.	Not covered
26	\$0.00		WiseEssentials 25 \$3,500 Deductible	PPO	PPO: \$3,500/no limit (no deductible for 1st 6 office visits per year) Non-PPO: \$7,000/no limit	75%	PPO: \$5,000/ no family limit Non-PPO: no maximum	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	PPO: exam paid same as an office visit; screenings (pap smear, PSA testing, cholesterol, etc.) no deductible & paid at 100%. Non-PPO: 50%. Immunizations not covered. No maximum per year.	Not covered
27	\$0.00		WiseSavings 20 \$3,400 Deductible HSA-qualified plan	PPO	\$3,400 aggregate per family	80%	PPO: \$5,100 aggregate per family Non-PPO: no maximum	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	PPO: no deductible & 100% paid for exams (\$300 max per year) & immunizations; screenings (pap smear, PSA testing, cholesterol, etc.) paid at 80% after deduc. Non-PPO: 60% (only screenings are covered for non-PPO).	Not covered
28	\$0.00		WiseSavings 20 \$6,000 Deductible HSA-qualified plan	PPO	\$6,000 aggregate per family	80%	PPO: \$3,500 aggregate per family Non-PPO: no maximum	\$0	Not covered	Not covered (but discounts are available at participating pharmacies)	PPO: no deductible & 100% paid for exams (\$300 max per year) & immunizations; screenings (pap smear, PSA testing, cholesterol, etc.) paid at 80% after deduc. Non-PPO: 60% (only screenings are covered for non-PPO).	Not covered

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29	\$0.00		Selections Comprehensive	POS	\$500/ \$1,500	80%	PPO: \$2,000/ \$6,000 Non-PPO: no maximum	\$15	Covered	No deductible; you pay: 50% (generic and brand-name formulary); non-formulary not covered; \$2,000 max benefit per year	No deductible; 100% after \$15 office visit copay to \$200 maximum per year for PPO providers only	Not covered (but discounts are available at participating optical providers)
30	\$0.00		Selections Comprehensive	POS	\$1,000/ \$3,000	80%	PPO: \$2,000/ \$6,000 Non-PPO: no maximum	\$15	Covered	No deductible; you pay: 50% (generic and brand-name formulary); non-formulary not covered; \$2,000 max benefit per year	No deductible; 100% after \$15 office visit copay to \$200 maximum per year for PPO providers only	Not covered (but discounts are available at participating optical providers)
31	\$0.00		Selections Catastrophic	POS	\$1,500/ \$4,500	80%	PPO: \$3,000/ \$9,000 Non-PPO: no maximum	\$15	Not covered	Not covered	Not covered	Not covered (but discounts are available at participating optical providers)
32	\$0.00		Preferred Comprehensive	PPO	\$750/ \$2,250	80%	PPO: \$2,000/ \$6,000 Non-PPO: no maximum	\$0	Covered	No deductible; you pay: 50% (generic and brand-name formulary); non-formulary not covered; \$2,000 max benefit per year	No deductible; 100% to \$300 maximum per year	No deductible for one routine exam per year paid at 100%; lenses & frames paid at 50% to \$400 each year after the annual deductible is satisfied

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33	\$0.00		Preferred Catastrophic	PPO	\$1,500/ \$4,500	80%	PPO: \$3,000/ \$9,000 Non-PPO: no maximum	\$0	Not covered	Not covered	Not covered	Not covered (but discounts are available at participating optical providers)
34	\$0.00		HSA Preferred Castastrophic <small>HSA-qualified plan</small>	PPO	\$5,000 aggregate per family	80%	PPO: \$5,000 aggregate per family Non-PPO: no maximum	\$0	Not covered	Not covered	No deductible; 80% (PPO) or 60% (Participating provider) to \$300 maximum per year	Not covered (but discounts are available at participating optical providers)
35	\$0.00		Breakthru 80	PPO	\$500/ \$1,500 (no deductible for office visits)	100% for office visits 80% for other services	PPO: \$2,500/ \$7,500 Non-PPO: no maximum	\$20 for PPO provider \$40 for Participating provider	Covered	No deductible; you pay: \$10 (generic); 30% (brand-name formulary) or 50% (non-formulary); \$3,000 max benefit per year	No deductible; 100% (PPO) or 50% (Participating provider) to \$400 maximum per year	No deductible; one routine exam per year paid at 100% (after office visit copay); lenses & frames paid at 100% to \$400 each calendar year
36	\$0.00		Breakthru 80	PPO	\$1,500/ \$4,500 (no deductible for office visits)	100% for office visits 80% for other services	PPO: \$2,500/ \$7,500 Non-PPO: no maximum	\$20 for PPO provider \$40 for Participating provider	Covered	No deductible; you pay: \$10 (generic); 30% (brand-name formulary) or 50% (non-formulary); \$3,000 max benefit per year	No deductible; 100% (PPO) or 50% (Participating provider) to \$400 maximum per year	No deductible; one routine exam per year paid at 100% (after office visit copay); lenses & frames paid at 100% to \$400 each calendar year

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37	\$0.00		Breakthru 70	PPO	\$1,000/ \$3,000 (no deductible for office visits)	100% for office visits 70% for other services	PPO: \$5,000/ \$15,000 Non-PPO: no maximum	\$30 for PPO provider \$40 for Participating provider	Covered	No deductible; you pay: \$10 (generic); 30% (brand-name formulary) or 50% (non-formulary); \$3,000 max benefit per year	No deductible; 70% (PPO) or 50% (Participating provider) to \$200 maximum per year	No deductible; one routine exam per year paid at 100% (after office visit copay); lenses & frames paid at 100% to \$200 each calendar year
38	\$0.00		Breakthru 70	PPO	\$3,000/ \$9,000 (no deductible for office visits)	100% for office visits 70% for other services	PPO: \$5,000/ \$15,000 Non-PPO: no maximum	\$30 for PPO provider \$40 for Participating provider	Covered	No deductible; you pay: \$10 (generic); 30% (brand-name formulary) or 50% (non-formulary); \$3,000 max benefit per year	No deductible; 70% (PPO) or 50% (Participating provider) to \$200 maximum per year	No deductible; one routine exam per year paid at 100% (after office visit copay); lenses & frames paid at 100% to \$200 each calendar year
39	\$0.00		Breakthru 50	PPO	\$2,500/ \$7,500	50%	PPO: \$10,000/ \$30,000 Non-PPO: no maximum	\$0	Not covered	Not covered	Not covered	Not covered (but discounts are available at participating optical providers)
40	\$0.00		Breakthru 50	PPO	\$5,000/ \$15,000	50%	PPO: \$10,000/ \$30,000 Non-PPO: no maximum	\$0	Not covered	Not covered	Not covered	Not covered (but discounts are available at participating optical providers)

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Notes Regarding Rates

The rates shown in this comparison are subject to change on the next contract renewal date shown below for that carrier.

Next Contract Renewal Date	Carrier
July 1, 2007	Regence BlueShield
January 1, 2008	LifeWise Health Plan
March 1, 2008	KPS Health Plans
April 1, 2008	Group Health Cooperative

A person's rate will change at the next contract renewal date if a person's birthday places them in the next higher 5-year age category during the contract year.

This comparison offers a brief summary of benefits and does not comprise a certificate of coverage or a contract. For full coverage provisions including all covered services, waiting periods, limitations and exclusions, please refer to a summary of benefits, the benefits brochure and contract. If any discrepancy exists between this summary and the carrier's contract, the contract will prevail.