INDIVIDUAL AND FAMILY PLANS

GroupHealth®

2016 Compare your plan options

IMPORTANT DATES
2016 open enrollment:* Nov. 1, 2015–Jan. 31, 2016

For coverage beginning	Deadline to enroll direct from Group Health	Deadline to enroll with Washington Healthplanfinder
Jan. 1, 2016	Dec. 23, 2015	Dec. 23, 2015
Feb. 1, 2016	Jan. 31, 2016	Jan. 23, 2016
March 1, 2016	Jan. 31, 2016	Jan. 31, 2016

Value-driven **Core network plans** and ALL NEW choice-driven **Access PPO plans**

*Certain qualifying events — such as if you lose your health coverage, or have a birth or adoption in your family — allow you to enroll in a health plan or modify your coverage at any time during the year, as long as it's no more than 60 days from the date of the qualifying event.

Everything you've been looking for in a health plan is right here

Our plans run the gamut—from plans with low premiums to those with maximum provider choice—so no matter what you're looking for you'll find it here. Great benefit coverage, value for your money, and choice of quality providers from our Core network or from our vast, nationwide Access PPO network.

No matter what plan you choose, you'll enjoy a whole host of services and ways to access your care. Because after you've done the hard work of finding the right plan, your plan should work hard for you.

Let's get started.

1 Check to see if you're in our area.

Check this list of counties to be sure you live where our plans are available.
Only our Core plans are available in the counties marked with an asterisk (*).

Benton*	Lewis	Thurston
Columbia*	Mason	Walla Walla*
Franklin*	Pierce	Whatcom
Island	San Juan	Whitman*
King	Skagit	Yakima*
Kitsap	Snohomish	
Kittitas*	Spokane	

2 Should you purchase your plan from us or through the exchange?

All of our plans are offered direct from Group Health, and purchasing from us means you'll get access to our full breadth of plans—including those with the most provider choice—and you'll enjoy a simple, streamlined application process. However, many of our plans are also available on Washington Healthplanfinder, with additional plans for those who meet one or more of these requirements:

- You qualify for financial assistance. (Visit wahealthplanfinder.org to find out.)
- You're under 30 or experiencing a qualifying hardship.
- You are American Indian or Alaska Native, making you eligible for low-cost or no-cost health coverage.

3 Which provider network appeals to you?

CORE network offers you access to specially selected providers, and this is where you'll find the greatest value.

ACCESS PPO network offers you virtually unlimited provider choice—including all of the providers in the Core network—by expanding the network nationwide.

4 Which metal tier works best when you consider your monthly budget and how much you'll pay when you access care?

Metal tiers	Monthly premium	Deductibles, coinsurance, copays
Bronze plans	$	$$$
Silver plans	$$	$$
Gold plans	$$$	$

5 Use this chart to further narrow your options.

	CORE Offered direct from Group Health and/or through Washington Healthplanfinder						ACCESS PPO Offered direct only from Group Health Options, Inc.				
YOU	Core Basics Plus* Page 6	Core Bronze HSA Page 6	Core Silver HSA & variations** Page 7 & 9	Flex Bronze Page 7	Flex Silver & variations** Page 7 & 8	Flex Gold Page 7	Access PPO Bronze HSA Page 10	Access PPO Silver HSA Page 10	Access PPO Bronze Page 11	Access PPO Silver Page 11	Access PPO Gold Page 11
Are eligible for financial assistance**		●	●	●	●	●					
Are eligible for cost share reductions when you get care**			●		●						
Want maximum provider choice							●	●	●	●	●
Want an HSA-compatible plan		●	●				●	●			
Don't expect to use a lot of health care services (lower premium, higher costs for care)	●	●		●			●		●		
Think your use of health care services will be moderate (balanced premium and costs for care)			●		●			●		●	
Expect to use a lot of health care services (higher premium, lower costs for care)						●					●
Want a low monthly premium and that is the most important thing	●	●		●			●		●		
Like the idea of a few visits ("up-front visits") before your deductible kicks in	●			●	●	●			●	●	●
Are an American Indian or Alaska Native (AIAN)	Our AIAN plans are not featured in this brochure. Find information at ghc.org/if and enroll at wahealthplanfinder.org.						Not available				

*Only available through Washington Healthplanfinder to those who are under 30 or experiencing some sort of hardship.
**Only available through Washington Healthplanfinder.

10 essential health benefits

All individual and family plans, regardless of carrier, cover at least 10 essential health benefits. Some plans, like ours, give you the option to purchase pediatric dental separate, from your medical plan. The other major difference you might see between carriers and plans is the level of coverage for each of these benefits.

1. **AMBULATORY PATIENT SERVICES**
   Office visits to your in-network primary care doctor or specialists, including naturopathy.

2. **EMERGENCY SERVICES**
   Issues that could lead to death or disability if you do not treat them.

3. **HOSPITALIZATION**
   Room and board, tests, drugs, and care from doctors and nurses while admitted; organ and tissue transplants, and hospice and respite care.

4. **MATERNITY AND NEWBORN CARE**
   Prenatal and postnatal care, delivery and inpatient maternity services, plus newborn child care.

5. **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT**
   Inpatient hospital and outpatient mental and behavioral health.

6. **PRESCRIPTION DRUGS**
   Retail, mail order, and specialty drugs.

7. **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES**
   To help gain or regain mental and physical skills in case of injury, disability, or chronic condition; includes inpatient rehabilitation; physical, speech, and occupational therapy; durable medical equipment; or skilled nursing.

8. **LABORATORY SERVICES**
   Lab tests, X-ray services, and pathology, and imaging and diagnostics such as MRI, CT scan, and PET scan.

9. **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT**
   Mammograms, colonoscopies, vaccines, and more; covered in full if you use in-network providers for care such as routine physicals, screening, and immunizations. Disease management coordinates care for diabetes, asthma, and other conditions.

10. **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE**
    Members under age 19 are covered for vision care (eye exam, lenses, and eyewear). Dental coverage includes preventive, basic, and major dental care.

Definitions and details

COINSURANCE
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, COPAY
The set dollar amount you pay when you receive certain covered services.

DEDUCTIBLE
What you'll pay each calendar year before your full coverage kicks in. Once a family member meets their individual deductible, services are covered for that person without the entire family deductible being met. Other family members continue to pay toward the family deductible amount. For certain services, the deductible does not apply.

HSA
A health savings account (HSA) is a personal savings account that's used to pay for eligible medical expenses. You can open an HSA with your own financial institution and the money you deposit in the account is not taxed; you own and control that money. Additionally, our HSA plans feature embedded deductibles, which means that if your plan covers more than one person, full coverage kicks in for each person when they meet the individual deductible (as opposed to having to wait for the full family deductible to be met).

OUT-OF-POCKET MAXIMUM
The most you'll be required to pay for covered services in a calendar year. Deductible, coinsurance, and copays count toward this limit. Some plans—our Access PPO plans—have an unlimited out-of-pocket maxmum for out-of-network benefits.

PREMIUM
The fee you pay each month for your health coverage, regardless of how much or how little you access care.

UPFRONT VISITS
Our non-HSA plans offer a handful (3, 4, or 5) of office visits not subject to the deductible. It's important to note that all in-network preventive care is covered in full, not subject to the deductible, and does not count as one of your upfront visits.

PRIMARY CARE (LOWER COPAY)
These types of care are considered primary care:

Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • General Practice • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

SPECIALTY CARE (HIGHER COPAY)
These types of care are considered specialty care:

Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition* • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

* Nutrition counseling may be covered as preventive when certain requirements are met.

Ready to apply?

You can mail in the enclosed application or enroll online at **ghc.org/if**, where you can also see information about our plans, dental coverage, health care reform, and even find a provider. See enrollment details on the back cover.

2016 Group Health Cooperative plans:
Core Provider Network

CALENDAR COSTS	CORE BASICS PLUS CATASTROPHIC* For adults under 30 or experiencing some sort of hardship	CORE BRONZE HSA
Annual deductible	$6,850 Indiv / $13,700 Family	$4,500 Indiv / $9,000 Family
Coinsurance	0%	20%
Out-of-pocket maximum	$6,850 Indiv / $13,700 Family	$6,450 Indiv / $12,900 Family
COMMONLY USED BENEFITS	**After deductible is met, you pay:**	**After deductible is met, you pay:**
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	**First 3 primary visits covered in full ◆** Primary: $0 Specialty: 0%	20%
Prescription drugs Costs per 30-day supply	Generic: 0% Brand: 0% Specialty: 0%	Generic: 20% Brand: 40% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 0% Brand: 0% Specialty: 0%	Generic: 15% Brand: 35% Specialty: 50%
Urgent care	$0	20%
Hospitalization	0%	20%
Emergency services	0%	20%
OTHER ESSENTIAL BENEFITS		
Preventive services	Covered in full ◆	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 0%	Covered in full ◆ 20%
Laboratory and radiology services	0%	20%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	0%	20%
Ambulatory outpatient services	0%	20%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆	Covered in full ◆

Dental coverage is required for those up to age 19. See the dental flyer for details about available dental plans and how to make sure you have the required pediatric dental coverage, if applicable.

◆ **DEDUCTIBLE DOES NOT APPLY**

*Only available through Washington Healthplanfinder

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

CORE SILVER HSA	FLEX BRONZE	FLEX SILVER	FLEX GOLD
$2,800 Indiv / $5,600 Family	$6,000 Indiv / $12,000 Family	$1,500 Indiv / $3,000 Family	$600 Indiv / $1,200 Family
10%	20%	30%	20%
$5,500 Indiv / $11,000 Family	$6,850 Indiv / $13,700 Family	$6,350 Indiv / $12,700 Family	$4,500 Indiv / $9,000 Family
After deductible is met, you pay:	**After deductible is met, you pay:**	**After deductible is met, you pay:**	**After deductible is met, you pay:**
10%	Primary: $40 **First 3 visits =** ◆, then 20% Specialty: 20%	**First 4 primary or specialty visits =** ◆ Primary: $20 Specialty: $45	**First 5 primary or specialty visits =** ◆ Primary: $10 Specialty: $30
Generic: 10% Brand: 30% Specialty: 50%	Generic: $25 ◆ Brand: 40% Specialty: 50%	Generic: $10 ◆ Brand: 40% Specialty: 50%	Generic: $10 ◆ Brand: $35 ◆ Specialty: 50%
Generic: 5% Brand: 25% Specialty: 50%	Generic: $20 ◆ Brand: 35% Specialty: 50%	Generic: $5 ◆ Brand: 35% Specialty: 50%	Generic: $5 ◆ Brand: $30 ◆ Specialty: 50%
10%	Primary: $40 or 20%	Primary: $20	Primary: $10
10%	20%	30%	20%
10%	20%	$200 + 30%	$200 + 20%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆
Covered in full ◆ 10%	Covered in full ◆ 20%	Covered in full ◆ 30%	Covered in full ◆ 20%
10%	20%	30%	20%
10%	20% 20% 20%	30% Specialty: $45 30%	20% Specialty: $30 20%
10%	20%	30%	20%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY**

PCY = Per Calendar Year

2016 Group Health Cooperative plans:
Core Provider Network

	FLEX SILVER 73*	FLEX SILVER 87*
CALENDAR COSTS		
Annual deductible	$1,350 Indiv / $2,700 Family	$400 Indiv / $800 Family
Coinsurance	30%	10%
Out-of-pocket maximum	$5,450 Indiv / $10,900 Family	$2,250 Indiv / $4,500 Family
COMMONLY USED BENEFITS	**After deductible is met, you pay:**	**After deductible is met, you pay:**
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	**First 4 primary or specialty visits = ◆** Primary: $20 Specialty: $45	**First 4 primary or specialty visits = ◆** Primary: $10 Specialty: $30
Prescription drugs Costs per 30-day supply	Generic: $10 ◆ Brand: 40% Specialty: 50%	Generic: $10 ◆ Brand: 30% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: $5 ◆ Brand: 35% Specialty: 50%	Generic: $5 ◆ Brand: 25% Specialty: 50%
Urgent care	Primary: $20	Primary: $10
Hospitalization	30%	10%
Emergency services	$200 + 30%	$200 + 10%
OTHER ESSENTIAL BENEFITS		
Preventive services	Covered in full ◆	Covered in full ◆
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 30%	Covered in full ◆ 10%
Laboratory and radiology services	30%	10%
Rehabilitative and habilitative services and devices Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	30% Specialty: $45 30%	10% Specialty: $30 10%
Ambulatory outpatient services	30%	10%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆	Covered in full ◆

Dental coverage is required for those up to age 19. See the dental flyer for details about available dental plans and how to make sure you have the required pediatric dental coverage, if applicable.

◆ **DEDUCTIBLE DOES NOT APPLY**

*Only available through Washington Healthplanfinder

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FLEX SILVER 94*	CORE SILVER HSA 73*	CORE SILVER HSA 87*	CORE SILVER HSA 94*
These plans are only available to those who qualify based on income			
$50 Indiv / $100 Family	$2,750 Indiv / $5,500 Family	$500 Indiv / $1,000 Family	$50 Indiv / $100 Family
5%	10%	10%	5%
$2,250 Indiv / $4,500 Family	$3,250 Indiv / $6,500 Family	$2,250 Indiv / $4,500 Family	$2,250 Indiv / $4,500 Family
After deductible is met, you pay:	**After deductible is met, you pay:**	**After deductible is met, you pay:**	**After deductible is met, you pay:**
First 4 primary or specialty visits = ◆ Primary: $0 Specialty: $5	10%	10%	5%
Generic: $7 ◆ Brand: 10% Specialty: 50%	Generic: 10% Brand: 20% Specialty: 50%	Generic: 10% Brand: 20% Specialty: 50%	Generic: 10% Brand: 15% Specialty: 50%
Generic: $2 ◆ Brand: 5% Specialty: 50%	Generic: 5% Brand: 15% Specialty: 50%	Generic: 5% Brand: 15% Specialty: 50%	Generic: 5% Brand: 10% Specialty: 50%
Primary: $0	10%	10%	5%
5%	10%	10%	5%
$200 + 5%	10%	10%	5%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆
Covered in full ◆ 5%	Covered in full ◆ 10%	Covered in full ◆ 10%	Covered in full ◆ 5%
5%	10%	10%	5%
5% Specialty: $5 5%	10%	10%	5%
5%	10%	10%	5%
Covered in full ◆	Covered in full ◆	Covered in full ◆	Covered in full ◆

◆ **DEDUCTIBLE DOES NOT APPLY**

PCY = Per Calendar Year

2016 Group Health Options, Inc. plans:
Access PPO Provider Network

Only sold in specific counties; see page 2 for details.

CALENDAR COSTS	ACCESS PPO BRONZE HSA In network **enhanced**	ACCESS PPO BRONZE HSA In network **standard**	ACCESS PPO BRONZE HSA Out of network	ACCESS PPO SILVER HSA In network **enhanced**	ACCESS PPO SILVER HSA In network **standard**	ACCESS PPO SILVER HSA Out of network
Annual deductible	$4,500 Indiv / $9,000 Family		$9,000 Indiv $18,000 Family	$2,700 Indiv / $5,400 Family		$5,400 Indiv $10,800 Family
Coinsurance	30%		50%	20%		50%
Out-of-pocket maximum	$6,450 Indiv / $12,900 Family		Unlimited	$5,000 Indiv / $10,000 Family		Unlimited
COMMONLY USED BENEFITS	**After deductible is met, you pay:**			**After deductible is met, you pay:**		
Office visits Primary and specialty care Acupuncture — 12 visits PCY Manipulative therapy — 10 visits PCY Adult vision exam — 1 exam PCY	20%	30%	50%	10%	20%	50%
Prescription drugs Costs per 30-day supply	Generic: 15% Brand: 35% Specialty: 50%	Generic: 20% Brand: 40% Specialty: 50%	Not covered	Generic: 5% Brand: 25% Specialty: 50%	Generic: 10% Brand: 30% Specialty: 50%	Not covered
Mail order prescription drugs Costs per 30-day supply, up to a 90-day supply except specialty	Generic: 15% Brand: 35% Specialty: 50%		Not covered	Generic: 5% Brand: 25% Specialty: 50%		Not covered
Urgent care	20%	30%	50%	10%	20%	50%
Hospitalization	30%		50%	20%		50%
Emergency services	30%		30%	20%		20%
OTHER ESSENTIAL BENEFITS						
Preventive services	Covered in full ◆		50%	Covered in full ◆		50%
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient / outpatient surgery	Covered in full ◆ 30%		50%	Covered in full ◆ 20%		50%
Laboratory and radiology services	30%		50%	20%		50%
Rehabilitative and habilitative services Inpatient rehabilitation — 30 days PCY Outpatient rehabilitation — 25 visits PCY Durable medical equipment (including prosthetics)	30% 20% 30%	30%	50%	20% 10% 20%	20%	50%
Ambulatory outpatient services	30%		50%	20%		50%
Pediatric vision Covered for members under age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ◆		Routine eye exam 50%	Covered in full ◆		Routine eye exam 50%

◆ **DEDUCTIBLE DOES NOT APPLY**

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement.Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

What is an "enhanced" benefit? Access PPO is the only PPO network that gives you in-network access to the quality doctors at Group Health Medical Centers. When you choose these doctors — and other high performing select Washington providers in the major areas we serve — you'll enjoy the reduced cost shares seen in the "In network enhanced" column.

ACCESS PPO BRONZE

In network **enhanced**	In network **standard**	Out of network
$6,000 Indiv / $12,000 Family		$12,000 Indiv $24,000 Family
30%		50%
$6,850 Indiv / $13,700 Family		Unlimited
After deductible is met, you pay:		
First 3 primary visits = ◆		50%
Primary: $40 first 3 visits ◆, then 20% Specialty: 20%	Primary: $50, first 3 visits ◆,then 30% Specialty: 30%	
Generic: $25 ◆ Brand: 35% Specialty: 50%	Generic: $30 ◆ Brand: 40% Specialty: 50%	Not covered
Generic: $25 ◆ Brand: 30% Specialty: 50%		Not covered
Primary: $40 or 20%	Primary: $50 or 30%	50%
30%		50%
30%		30%
Covered in full ◆		50%
Covered in full ◆ 30%		50%
30%		50%
30% Specialty: 20% 30%	30% Specialty: 30% 30%	50%
30%		50%
Covered in full ◆		Routine eye exam 50%

ACCESS PPO SILVER

In network **enhanced**	In network **standard**	Out of network
$1,750 Indiv / $3,500 Family		$3,500 Indiv $7,000 Family
30%		50%
$6,350 Indiv / $12,700 Family		Unlimited
After deductible is met, you pay:		
First 4 primary or specialty visits = ◆		50%
Primary: $20 Specialty: $45	Primary: $30 Specialty: $55	
Generic: $5 ◆ Brand: 35% Specialty: 50%	Generic: $10 ◆ Brand: 40% Specialty: 50%	Not covered
Generic: $5 ◆ Brand: 35% Specialty: 50%		Not covered
Primary: $20	Primary: $30	50%
30%		50%
$200 + 30%		$200 + 30%
Covered in full ◆		50%
Covered in full ◆ 30%		50%
30%		50%
30% Specialty: $45 30%	30% Specialty: $55 30%	50%
30%		50%
Covered in full ◆		Routine eye exam 50%

ACCESS PPO GOLD

In network **enhanced**	In network **standard**	Out of network
$1,000 Indiv / $2,000 Family		$2,000 Indiv $4,000 Family
20%		50%
$4,500 Indiv / $9,000 Family		Unlimited
After deductible is met, you pay:		
First 5 primary or specialty visits = ◆		50%
Primary: $10 Specialty: $30	Primary: $20 Specialty: $40	
Generic: $5 ◆ Brand: $30 ◆ Specialty: 50%	Generic: $10 ◆ Brand: $35 ◆ Specialty: 50%	Not covered
Generic: $5 ◆ Brand: $30 ◆ Specialty: 50%		Not covered
Primary: $10	Primary: $20	50%
20%		50%
$200 + 20%		$200 + 20%
Covered in full ◆		50%
Covered in full ◆ 20%		50%
20%		50%
20% Specialty: $30 20%	20% Specialty: $40 20%	50%
20%		50%
Covered in full ◆		Routine eye exam 50%

Dental coverage is required for those up to age 19. See the dental flyer for details about available dental plans and how to make sure you have the required pediatric dental coverage, if applicable.

◆ **DEDUCTIBLE DOES NOT APPLY**

PCY = Per Calendar Year

READY TO APPLY?

- Visit **ghc.org/if** or mail in the enclosed application to enroll directly with Group Health.
- Contact your producer (agent/broker).
- If you qualify for financial assistance, are under 30 or experiencing some kind of hardship, or are an American Indian or Alaska Native, it's to your advantage to enroll in our plans through **wahealthplanfinder.org.**
- You can also call us at **206-448-4141** or **1-800-358-8815**. If you're hearing- or speech-impaired, call the Washington state TTY Relay number at **1-800-833-6388** or **711**.

GroupHealth®

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