

Group Health
Certificate of Coverage

City of Seattle – Early Retirees

January 1, 2009



GroupHealth

Group Medical Coverage Agreement

Group Health Cooperative (also referred to as “GHC”) is a nonprofit health maintenance organization furnishing health care coverage on a prepayment basis. The Group identified below wishes to purchase such coverage. This Agreement sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties; requirements for enrollment and eligibility; and benefits to which those enrolled under this Agreement are entitled.

The Agreement between GHC and the Group consists of the following:

- Standard Provisions
- Attached Benefit Booklet
- Signed Group application
- Premium Schedule
- All attachments and endorsements included or issued hereafter

Group Health Cooperative

Signed: 

 Title: President and Chief Executive Officer

City of Seattle - Early Retirees, 1004400, 4911700

Signed: _____
 Title: _____

This Agreement will continue in effect until terminated or renewed as herein provided for and is effective January 1, 2009.

PA-113302
C27659-1004400

**Group Medical Coverage Agreement
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Standard Provisions

Attachment 1 Benefit Booklet

Attachment 2 Premium Schedule

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Standard Provisions

1. GHC agrees to provide benefits as set forth in the attached Benefit Booklet to enrollees of the Group.
2. **Monthly Premium Payments.** For the initial term of this Agreement, the Group shall submit to GHC for each Member the monthly premiums set forth in the current Premium Schedule and a verification of enrollment. Payment must be received on or before the due date and is subject to a grace period of ten (10) days. Premiums are subject to change by GHC upon thirty (30) days written notice. Premium rates will be revised as a part of the annual renewal process.

In the event the Group increases or decreases enrollment at least twenty-five percent (25%) or more, GHC reserves the right to require re-rating of the Group.

3. **Dissemination of Information.** Unless the Group has accepted responsibility to do so, GHC will disseminate information describing benefits set forth in the Benefit Booklet attached to this Agreement.
4. **Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under this Agreement.
5. **Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of this Agreement. *This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.*
6. **Modification of Agreement.** Except as required by federal and Washington State law, this Agreement may not be modified without agreement between both parties.

No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

7. **Indemnification.** GHC agrees to indemnify and hold the Group harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of GHC's failure to perform, negligent performance or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The Group agrees to indemnify and hold GHC harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of the Group's failure to perform, negligent performances or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

The indemnifying party shall give the other party prompt notice of any claim covered by this section and provide reasonable assistance (at its expense). The indemnifying party shall have the right and duty to assume the control of the defense thereof with counsel reasonably acceptable to the other party. Either party may take part in the defense at its own expense after the other party assumes the control thereof.

8. **Compliance With Law.** The Group and GHC shall comply with all applicable state and federal laws and regulations in performance of this Agreement.

This Agreement is entered into and governed by the laws of Washington State, except as otherwise pre-empted by ERISA and other federal laws.

9. **Governmental Approval.** If GHC has not received any necessary government approval by the date when notice is required under this Agreement, GHC will notify the Group of any changes once governmental approval has been received. GHC may amend this Agreement by giving notice to the Group upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All

amendments are deemed accepted by the Group unless the Group gives GHC written notice of non-acceptance within thirty (30) days after receipt of amendment, in which event this Agreement and all rights to services and other benefits terminate the first of the month following thirty (30) days after receipt of non-acceptance.

10. Confidentiality. Each party acknowledges that performance of its obligations under this Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Group's employees (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and employee information as required by applicable law.

11. Arbitration. Any dispute, controversy or difference between GHC and the Group arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration in Seattle, Washington in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Except as may be required by law, neither party nor arbitrator may disclose the existence, content or results of any arbitration hereunder without the prior written consent of both parties.

12. HIPAA.

Definition of Terms. Terms used, but not otherwise defined, in this Section shall have the same meaning as those terms have in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Transactions Accepted. GHC will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. If the Group sends transactions to GHC that do not comply with applicable HIPAA standards, the Group will be deemed by such action to be representing and warranting that it is not a Covered Entity or otherwise required to comply with HIPAA standards for electronic transactions, either directly, or as an agent of another individual or entity. The parties agree that all the terms, conditions, representations and warranties contained in this section are express obligations of the Group, and the Group shall indemnify GHC for any breach of this section.

13. Termination of Entire Agreement. This is a guaranteed renewable Agreement and cannot be terminated without the mutual approval of each of the parties, except in the circumstances set forth below.

a. Nonpayment or Non-Acceptance of Premium. Failure to make any monthly premium payment or contribution in accordance with subsection 2 above shall result in termination of this Agreement as of the premium due date. The Group's failure to accept the revised premiums provided as part of the annual renewal process shall be considered nonpayment and result in non-renewal of this Agreement. The Group may terminate this Agreement upon fifteen (15) days written notice of premium increase, as set forth in subsection 2 above.

b. Misrepresentation. GHC may rescind or terminate this Agreement upon written notice in the event that *intentional* misrepresentation, fraud or omission of information was used in order to obtain Group coverage. Either party may terminate this Agreement in the event of *intentional* misrepresentation, fraud or omission of information by the other party in performance of its responsibilities under this Agreement.

- c. **Underwriting Guidelines.** GHC may terminate this Agreement in the event the Group no longer meets underwriting guidelines established by GHC that were in effect at the time the Group was accepted.
- d. ***Federal or State Law.*** *GHC may terminate this Agreement in the event there is a change in federal or state law that no longer permits the continued offering of the coverage described in this Agreement.*

14. Withdrawal or Cessation of Services.

- a. GHC may determine to withdraw from a Service Area or from a segment of its Service Area after GHC has demonstrated to the Washington State Office of the Insurance Commissioner that GHC's clinical, financial or administrative capacity to service the covered Members would be exceeded.
- b. GHC may determine to cease to offer the Group's current plan and replace the plan with another plan offered to all covered Members within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. GHC may also allow unrestricted conversion to a fully comparable GHC product.

GHC will provide written notice to each covered Member of the discontinuation or non-renewal of the plan at least ninety (90) days prior to discontinuation.

Dear Group Health Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2009 Group Health Benefit Booklet (Certificate of Coverage). It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Cooperative. Sections of this document may be ***bolded and italicized***, which identifies changes that Group Health has made to the plan. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health for your healthcare coverage. If you are eligible for Medicare, please read Section IV.J. as it may affect your prescription drug coverage.

We recommend you read it carefully so you'll understand not only the benefits, but the exclusions, limitations, and eligibility requirements of this certificate. Please keep this certificate for as long as you are covered by Group Health. We will send you revisions if there are any changes in your coverage.

This certificate is not the contract itself; you can contact your employer or group administrator if you wish to see a copy of the contract (Medical Coverage Agreement).

We'll gladly answer any questions you might have about your Group Health benefits. Please call our Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Thank you for choosing Group Health Cooperative. We look forward to working with you to preserve and enhance your health.

Very truly yours,

Scott Armstrong
President

PA-113302a, CA-1395a02,CA-1984,CA-3204,CA-2886,CA-11702,CA-2885,CA-1385
C27659-1004400a

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Section I. Introduction

Group Health Cooperative (also referred to as “GHC”) is a nonprofit health maintenance organization furnishing health care primarily on a prepayment basis.

Read This Benefit Booklet Carefully

This Benefit Booklet is a statement of benefits, exclusions and other provisions, as set forth in the Group Medical Coverage Agreement (“Agreement”) between GHC and the employer or Group.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Schedule of Benefits, Section IV; General Exclusions, Section V; and Allowances Schedule, Section II. These sections must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized. They are defined in Section VIII.

A. Accessing Care

Members are entitled to Covered Services only at GHC Facilities and from GHC Personal Physicians. Except as follows:

- Emergency care,
- Self-Referral to women’s health care providers, as set forth below,
- Visits with GHC-Designated Self-Referral Specialists, as set forth below,
- Care provided pursuant to a Referral. Referrals must be requested by the Member’s Personal Physician and approved by GHC, and
- Other services as specifically set forth in the Allowances Schedule and Section IV.

Primary Care. Members must select a GHC Personal Physician when enrolling under the Agreement. One Personal Physician may be selected for an entire family, or a different Personal Physician may be selected for each family member. If the Personal Physician is not selected at the time of enrollment, GHC will assign a Personal Physician, and a letter of explanation will be sent to the Member.

Selecting a Personal Physician or changing from one Personal Physician to another can be accomplished by contacting GHC Customer Service, or accessing the GHC website at www.ghc.org. The change will be made within twenty-four (24) hours of the receipt of the request, if the selected physician’s caseload permits.

A listing of GHC Personal Physicians, Referral specialists, women’s health care providers and GHC-Designated Self-Referral Specialists is available by contacting GHC Customer Service at (206) 901-4636 or (888) 901-4636, or by accessing GHC’s website at www.ghc.org.

In the case that the Member’s Personal Physician no longer participates in GHC’s network, the Member will be provided access to the Personal Physician for up to sixty (60) days following a written notice offering the Member a selection of new Personal Physicians from which to choose.

Specialty Care. Unless otherwise indicated in this section, the Allowances Schedule or Section IV., Referrals are required for specialty care and specialists.

GHC-Designated Self-Referral Specialist. Members may make appointments directly with GHC-Designated Self-Referral Specialists at Group Health-owned or -operated medical centers without a Referral from their Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy*, smoking cessation, speech/language and learning services* and urology.

* Medicare patients need *prior authorization* for these specialists.

Women's Health Care Direct Access Providers. Female Members may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Licensed Midwife, Doctor of Osteopathy, Pediatrician, Obstetrician or Advanced Registered Nurse Practitioner who is contracted by GHC to provide women's health care services directly, without a Referral from their Personal Physician, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Member's Personal Physician had been consulted, subject to any applicable Cost Shares, as set forth in the Allowances Schedule. If the Member's women's health care provider diagnoses a condition that requires Referral to other specialists or hospitalization, the Member or her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHC requirements.

Second Opinions. The Member may access, upon request, a second opinion regarding a medical diagnosis or treatment plan from a GHC Provider.

Emergent and Urgent Care. Emergent care is available at GHC Facilities. If Members cannot get to a GHC Facility, Members may obtain Emergency services from the nearest hospital. Members or persons assuming responsibility for a Member must notify GHC by way of the GHC Emergency Notification Line within twenty-four (24) hours of admission to a non-GHC Facility, or as soon thereafter as medically possible. Members may refer to Section IV. for more information about coverage of Emergency services.

In the GHC Service Area, urgent care is covered only at GHC medical centers, GHC urgent care clinics or GHC Provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider. Members may refer to Section IV. for more information about coverage of urgent care services.

Outside the GHC Service Area, urgent care is covered at any medical facility. Members may refer to Section IV. for more information about coverage of urgent care services.

Recommended Treatment. GHC's Medical Director or his/her designee will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment, made in good faith, will be final.

Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended treatment or diagnostic plan to the extent permitted by law. Members who obtain care not recommended by GHC, do so with the full understanding that GHC has no obligation for the cost, or liability for the outcome, of such care. Coverage decisions may be appealed as set forth in Section VI.

Major Disaster or Epidemic. In the event of a major disaster or epidemic, GHC will provide coverage according to GHC's best judgment, within the limitations of available facilities and personnel. GHC has no liability for delay or failure to provide or arrange Covered Services to the extent facilities or personnel are unavailable due to a major disaster or epidemic.

Unusual Circumstances. If the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of facilities, military action, civil disorder, labor disputes or similar causes, GHC shall provide or arrange for services that, in the reasonable opinion of GHC's Medical Director, or his/her designee, are emergent or urgently needed. In regard to nonurgent and routine services, GHC shall make a good faith effort to provide services through its then-available facilities and personnel. GHC shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected. In no case shall GHC have any liability or obligation on account of delay or failure to provide or arrange such services.

B. Cost Shares

The Subscriber shall be liable for the following Cost Shares when services are received by the Subscriber and any of his/her Dependents.

1. **Copayments.** Members shall be required to pay Copayments at the time of service as set forth in the Allowances Schedule. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service.
2. **Coinsurance.** Members shall be required to pay coinsurance for certain Covered Services as set forth in the Allowances Schedule.
3. **Out-of-Pocket Limit.** Total Out-of-Pocket Expenses incurred during the same calendar year shall not exceed the Out-of-Pocket Limit set forth in the Allowances Schedule. Out-of-Pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in the Allowances Schedule.

C. Subscriber's Liability

The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Cost Share amounts for Covered Services provided to the Subscriber and his/her Dependents, as set forth in the Allowances Schedule; and (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents, at the time of service.

Payment of an amount billed by GHC must be received within thirty (30) days of the billing date.

D. Claims

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under the Agreement, a Member (or the Member's authorized representative) must contact GHC Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

If a Member receives a bill for services the Member believes are covered under the Agreement, the Member must, within ninety (90) days of the date of service, or as soon thereafter as reasonably possible, either (1) contact GHC Customer Service to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to GHC, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the date of service.

GHC will generally process claims for benefits within the following timeframes after GHC receives the claims:

- Pre-service claims – within fifteen (15) days.
- Claims involving urgently needed care – within seventy-two (72) hours.
- Concurrent care claims – within twenty-four (24) hours.
- Post-service claims – within thirty (30) days.

Timeframes for pre-service and post-service claims can be extended by GHC for up to an additional fifteen (15) days. Members will be notified in writing of such extension prior to the expiration of the initial timeframe.

Section II. Allowances Schedule

The benefits described in this schedule are subject to all provisions, limitations and exclusions set forth in the Group Medical Coverage Agreement.

“Welcome” Outpatient Services Waiver

Not applicable.

Annual Deductible

No annual Deductible.

Plan Coinsurance

No Plan Coinsurance.

Lifetime Maximum

\$2,000,000 per Member for Covered Services incurred, unless otherwise indicated. Up to \$5,000 is restored automatically each January 1 for benefits paid by GHC during the prior calendar year.

Hospital Services

- Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)
Covered subject to the lesser of GHC’s charge or a \$200 Copayment per Member per admission.
- Covered outpatient hospital surgery (including ambulatory surgical centers)
Covered subject to the lesser of GHC’s charge or the applicable outpatient services Copayment.

Outpatient Services

- Covered outpatient medical and surgical services
Covered subject to the lesser of GHC’s charge or a \$15 outpatient services Copayment per Member per visit.
- Allergy testing
Covered subject to the lesser of GHC’s charge or the applicable outpatient services Copayment.
- Oncology (radiation therapy, chemotherapy)
Covered subject to the lesser of GHC’s charge or the applicable outpatient services Copayment.

Drugs – Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies)

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHC drug formulary
Covered subject to the lesser of GHC’s charge or a \$15 Copayment for generic drugs or a \$30 Copayment for brand name drugs.

- Over-the-counter drugs and medicines

Not covered.

- Allergy serum

Covered subject to the lesser of GHC's charge or the applicable prescription drug Cost Share (as set forth above) for each thirty (30) day supply.

- Injectables

Injections that can be self-administered are subject to the lesser of GHC's charge or the applicable prescription drug Cost Share (as set forth above). Injections necessary for travel are not covered.

- Mail order drugs and medicines

Covered subject to the lesser of GHC's charge or the applicable prescription drug Cost Share (as set forth above) for each thirty (30) day supply or less.

Out-of-Pocket Limit

Limited to an aggregate maximum of \$2,000 per Member or \$4,000 per family per calendar year. Except as otherwise noted in this Allowances Schedule, the total Out-of-Pocket Expenses for the following Covered Services are included in the Out-of-Pocket Limit:

- Inpatient services
- Outpatient services
- Emergency care at a GHC or non-GHC Facility
- Ambulance services

Acupuncture

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment for Self-Referrals to a GHC Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year. When approved by GHC, additional visits are covered.

Ambulance Services

- Emergency ground/air transport

Covered at 80%.

- Non-emergent ground/air interfacility transfer

Covered at 80% for GHC-initiated transfers, except hospital-to-hospital ground transfers covered in full.

Chemical Dependency

- Inpatient services

Covered subject to the lesser of GHC's charge or the applicable inpatient services Copayment.

- Outpatient services

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment.

- Benefit period Allowance

Covered up to **\$14,500** per Member per any twenty-four (24) consecutive calendar month period.

Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.

Dental Services (including accidental injury to natural teeth)

Not covered, except as set forth in Section IV.B.23.

Devices, Equipment and Supplies (for home use)

Covered at 80% for:

- Durable medical equipment
- Orthopedic appliances
- Post-mastectomy bras limited to two (2) every six (6) months

Covered at 80% for:

- Ostomy supplies
- Prosthetic devices

When provided in a home health setting in lieu of hospitalization as described in Section IV.A.3., benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting.

Diabetic Supplies

Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.

Diagnostic Laboratory and Radiology Services

Covered in full.

Emergency Services

- At a GHC Facility

Covered subject to the lesser of GHC's charge or a \$100 Copayment per Member per Emergency visit. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

- At a non-GHC Facility

Covered subject to the lesser of GHC's charge or a \$150 **Copayment** per Member per Emergency visit. **Copayment** is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment.

- Hearing aids, including hearing aid examinations

Covered up to a \$1,000 maximum per ear during any consecutive thirty-six (36) month period.

Home Health Services

Covered in full. No visit limit.

Hospice Services

Covered in full. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence.

Infertility Services (including sterility)

Not covered.

Manipulative Therapy

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment for Self-Referrals to a GHC Provider for manipulative therapy of the spine and extremities in accordance with GHC clinical criteria up to a maximum of ten (10) visits per Member per calendar year.

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

Covered subject to the lesser of GHC's charge or the applicable inpatient services Copayment.

- Prenatal and postpartum care

Routine care covered in full. Non-routine care covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment.

- Pregnancy termination

Covered subject to the lesser of GHC's charge or the applicable Copayment for involuntary/voluntary termination of pregnancy.

Mental Health Services

- Inpatient services

Covered subject to the lesser of GHC's charge or the applicable inpatient services Copayment at a GHC-approved mental health care facility.

- Outpatient services

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment.

Naturopathy

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment for Self-Referrals to a GHC Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year. When approved by GHC, additional visits are covered.

Nutritional Services

- Phenylketonuria (PKU) supplements

Covered in full.

- Enteral therapy (formula)

Covered at 80% for elemental formulas. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

- Parenteral therapy (total parenteral nutrition)

Covered in full for parenteral formulas. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Obesity Related Services

Services directly related to obesity, including bariatric surgery, weight loss programs, medications and related physician visits for medication monitoring are not covered.

On the Job Injuries or Illnesses

Not covered, including injuries or illnesses incurred as a result of self-employment.

Optical Services

- Routine eye examinations

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment once every twelve (12) months.

- Lenses, including contact lenses, and frames

Not covered, except contact lens after cataract surgery is covered in full when in lieu of an intraocular lens.

Organ Transplants

Covered subject to the lesser of GHC's charge or the applicable Copayment.

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

- Surgery to correct a congenital disease or anomaly, or conditions following an injury or resulting from surgery

Covered subject to the lesser of GHC's charge or the applicable Copayment.

- Cosmetic surgery, including complications resulting from cosmetic surgery

Not covered.

Podiatric Services

- Medically Necessary foot care

Covered subject to the lesser of GHC's charge or the applicable Copayment.

- Foot care (routine)

Not covered, except in the presence of a non-related Medical Condition affecting the lower limbs.

Pre-Existing Condition

Covered with no wait.

Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms and prostate/colorectal cancer screening)

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment when in accordance with the well care schedule established by GHC. Eye refractions are not included under preventive care. Physicals for travel, employment, insurance or license are not covered.

Rehabilitation Services

- Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

Covered subject to the lesser of GHC's charge or the applicable inpatient services Copayment for up to sixty (60) days per calendar year.

- Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under

Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment for up to sixty (60) visits per calendar year.

Sexual Dysfunction Services

Not covered.

Skilled Nursing Facility (SNF)

Covered up to sixty (60) days per Member per calendar year.

Sterilization (vasectomy, tubal ligation)

Covered subject to the lesser of GHC's charge or the applicable Copayments.

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

Covered subject to the lesser of GHC's charge or the applicable Copayment up to \$1,000 maximum per Member per calendar year.

- Lifetime benefit maximum

Covered up to \$5,000 per Member.

Tobacco Cessation

- Individual/group sessions

Covered in full.

- Approved pharmacy products

Covered in full for each thirty (30) day supply or less of a prescription or refill when prescribed by a GHC Provider and obtained at a GHC Facility.

Section III. Eligibility, Enrollment and Termination

A. Eligibility

In order to be accepted for enrollment and continuing coverage under the Agreement, individuals must meet any eligibility requirements imposed by the Group, reside or work in the Service Area and meet all applicable requirements set forth below, except for temporary residency outside the Service Area for purposes of attending school, court-ordered coverage for Dependents or other unique family arrangements, when approved in advance by GHC. GHC has the right to verify eligibility.

1. Subscribers. Bona fide retirees who were enrolled under the Agreement for active employees on the date of retirement shall be eligible. A bona fide retiree is defined as an individual who is no longer working on a full- or part-time basis for the Group and begins receiving pension checks immediately following termination of employment with the Group.

2. Dependents. The Subscriber may also enroll the following:

- a. The Subscriber's legal spouse (unless legally separated);
- b. The Subscriber's domestic partner, provided that the application has been submitted to and approved by the Group and GHC, and that the Subscriber and domestic partners:
 - i. Share the same regular and permanent residence;
 - ii. Have a close personal relationship;
 - iii. Are jointly responsible for "basic living expenses" as defined by the Group;
 - iv. Are not married to anyone;
 - v. Are each eighteen (18) years of age or older;
 - vi. Are not related by blood closer than would bar marriage in the State of Washington;
 - vii. Were mentally competent to consent to contract when the domestic partnership began; and
 - viii. Are each other's sole domestic partner and are responsible for each other's common welfare.

Following termination of a domestic partnership a statement of termination must be filed with the Group. Application for another domestic partnership cannot be filed for ninety (90) days following a filing of the statement of termination of domestic partnership with the Group, unless such termination is due to the death of the domestic partner.

- c. Unmarried dependent children who are under the age of twenty-five (25).

"Children" means the children of the Subscriber, including adopted children, stepchildren, children for whom the Subscriber has a qualified court order to provide coverage, children of a domestic partner and any other children for whom the Subscriber is the legal guardian.

Eligibility may be extended past the Dependent's limiting age as set forth above if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age set forth above, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be furnished to GHC upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.

3. Temporary Coverage for Newborns. When a Member gives birth, the newborn will be entitled to the benefits set forth in Section IV. from birth through three (3) weeks of age. After three (3) weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled under the Agreement. All contract provisions, limitations and exclusions will apply except Section III.F. and III.G.

B. Enrollment

- 1. Application for Enrollment.** Application for enrollment must be made on an application approved by GHC. Applicants will not be enrolled or premiums accepted until the completed application has been approved by GHC. The Group is responsible for submitting completed applications to GHC.

GHC reserves the right to refuse enrollment to any person whose coverage under any Medical Coverage Agreement issued by Group Health Cooperative or Group Health Options, Inc. has been terminated for cause, as set forth in Section III.E. below.

- a. Newly Eligible Persons.** Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible.
- b. New Dependents.** A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within thirty-one (31) days after the dependency occurs.

A written application for enrollment of a newborn child must be made to the Group within sixty (60) days following the date of birth, when there is a change in the monthly premium payment as a result of the additional Dependent.

A written application for enrollment of an adoptive child must be made to the Group within sixty (60) days from the day the child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes total or partial financial support of the child, if there is a change in the monthly premium payment as a result of the additional Dependent.

When there is no change in the monthly premium payment, it is strongly advised that the Subscriber enroll the newborn or newly adoptive child as a Dependent with the Group to avoid delays in the payment of claims.

- c. Open Enrollment.** GHC will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during a limited period of time specified by the Group and GHC.
- d. Special Enrollment.**
 - GHC will allow special enrollment for persons:
 - who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
 - cessation of employer contributions,
 - exhaustion of COBRA continuation coverage,
 - loss of eligibility, except for loss of eligibility for cause; or
 - who have had such other coverage exhausted because such person reached a Lifetime Maximum limit.

GHC or the Group may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage under the Agreement must be made within thirty-one (31) days of the termination of previous coverage.

- GHC will allow special enrollment for the person eligible to be a Subscriber, his/her spouse and the newly acquired Dependent in the event one of the following occurs:
 - marriage. Application for coverage under the Agreement must be made within thirty-one (31) days of the date of marriage.
 - birth. Application for coverage under the Agreement must be made within sixty (60) days of the date of birth.
 - adoption or placement for adoption. Application for coverage under the Agreement must be made within sixty (60) days of the adoption or placement for adoption.
 - eligibility for medical assistance: provided such person is otherwise eligible for coverage under this Agreement, when approved and requested in advance by the Department of Social and Health Services (DSHS).

2. **Limitation on Enrollment.** The Agreement will be open for applications for enrollment as set forth in this Section III.B. Subject to prior approval by the Washington State Office of the Insurance Commissioner, GHC may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that GHC's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

C. Effective Date of Enrollment

1. Provided eligibility criteria are met and applications for enrollment are made as set forth in Sections III.A. and III.B. above, enrollment will be effective as follows:
 - Enrollment for a newly retired Subscriber and listed Dependents is effective on the first (1st) of the month following the date of retirement or expiration of COBRA coverage.
 - Enrollment for newly acquired domestic partners will begin on the date the affidavit is signed, and for newly acquired spouses will begin on the date of marriage.
 - Enrollment for all other newly dependent persons, other than newborns, adopted children, or children for whom the Subscriber becomes a legal guardian will begin on the first (1st) of the month following application.
 - Enrollment for newborns is effective from the date of birth.
 - Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes total or partial financial support of the child.
2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above. If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility. The Member will be transferred when a GHC Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. Eligibility for Medicare

Actively Employed Members and Spouses. Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), actively employed Members and their spouses who are eligible for Medicare benefits must decide whether to choose the benefits of the Agreement or the Medicare program as their primary source of health care coverage. The Group is responsible for providing the Member with necessary information regarding TEFRA eligibility and the selection process.

Members Residing Outside the GHC Medicare Advantage Service Area and Not Actively Employed. If a Member who is not actively employed or their spouse is or becomes eligible for Medicare, GHC requests that, effective the date that Medicare becomes the primary payer, the Member or their spouse enroll in and maintain both Medicare Parts A and B coverage.

An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status.

Members Residing Inside the GHC Medicare Advantage Service Area and Not Actively Employed. If a Member who is not actively employed or their spouse is or becomes eligible for Medicare, they must, effective the date that Medicare becomes the primary payer, enroll in and maintain both Medicare Parts A and B coverage and enroll in the GHC Medicare Advantage Plan. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under the Agreement.

An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

All applicable provisions of the GHC Medicare Advantage Plan are fully set forth in the Medicare Endorsement(s) attached to the Agreement (if applicable).

E. Termination of Coverage

1. **Termination of Specific Members.** *Individual Member coverage* may be terminated for any of the following reasons:
 - a. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in Section III., and is not enrolled for continuation coverage as described in Section III.G. below, coverage under the Agreement will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.
 - b. **For Cause.** Coverage of a Member may be terminated upon ten (10) working days written notice for:
 - i. Material misrepresentation, fraud or omission of information in order to obtain coverage.
 - ii. Permitting the use of a GHC identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

In the event of termination for cause, GHC reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses or other damages.

- c. **Premium Payments.** Nonpayment of premiums or contribution for a specific Member by the Group.
- d. **Failure to apply for Medicare.** *To the extent permitted under all applicable laws and regulations, when a Member who is eligible for Medicare benefits by reason of age fails to apply for a Medicare plan.*

In no event will a Member be terminated solely on the basis of their physical or mental condition provided they meet all other eligibility requirements set forth in the Agreement.

Any Member may appeal a termination decision through GHC's grievance process as set forth in Section VI.

2. **Certificate of Creditable Coverage.** Unless the Group has chosen to accept this responsibility, a certificate of creditable coverage (which provides information regarding the Member's length of coverage under the Agreement) will be issued automatically upon termination of coverage, and may also be obtained upon request.

F. Services After Termination of Agreement

1. **Members Hospitalized on the Date of Termination.** A Member who is receiving Covered Services as a registered bed patient in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:
 - According to GHC clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
 - The remaining benefits available under the Agreement for the hospitalization are exhausted, regardless of whether a new calendar year begins.
 - The Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
 - The Member becomes enrolled under an agreement with another carrier that would provide benefits for the hospitalization if the Agreement did not exist.
 - The Member becomes eligible for Medicare.

This provision will not apply if the Member is covered under another agreement that provides benefits for the hospitalization at the time coverage would terminate, except as set forth in this section, or if the Member is eligible for COBRA continuation coverage as set forth in subsection G. below.

2. **Services Provided After Termination.** The Subscriber shall be liable for payment of all charges for services and items provided to the Subscriber and all Dependents after the effective date of termination, except those services covered under subsection F.1. above. Any services provided by GHC will be charged according to the Fee Schedule.

G. Continuation of Coverage Options

- 1. Continuation Option.** A Member no longer eligible for coverage under the Agreement (except in the event of termination for cause, as set forth in Section III.E.) may continue coverage for a period of up to three (3) months subject to notification to and self-payment of premiums to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This continuation option is not available if the Group no longer has active employees or otherwise terminates.
- 2. Continuation Coverage Under Federal Law.** This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and only applies to grant continuation of coverage rights to the extent required by federal law.

Upon loss of eligibility, continuation of Group coverage may be available to a Member for a limited time after the Member would otherwise lose eligibility, if required by COBRA. The Group shall inform Members of the COBRA election process and how much the Member will be required to pay directly to the Group.

- 3. GHC Group Conversion Plan.** Members whose eligibility for coverage under the Agreement, including continuation coverage, is terminated for any reason other than cause, as set forth in Section III.E.1.b., and who are not eligible for Medicare or covered by another group health plan, may convert to GHC's Group Conversion Plan. If the Agreement terminates, any Member covered under the Agreement at termination may convert to a GHC Group Conversion Plan, unless he/she is eligible to obtain other group health coverage within thirty-one (31) days of the termination of the Agreement.

An application for conversion must be made within thirty-one (31) days following termination of coverage under the Agreement. Coverage under GHC's Group Conversion Plan is subject to all terms and conditions of such plan, including premium payments. A physical examination or statement of health is not required for enrollment in GHC's Group Conversion Plan. The Pre-Existing Condition limitation under GHC's Group Conversion Plan will apply only to the extent that the limitation remains unfulfilled under the Agreement.

By exercising Group Conversion rights, the Member may waive guaranteed issue and Pre-Existing Condition waiver rights under Federal regulations.

Persons wishing to purchase GHC's Individual and Family coverage should contact Group Health Marketing.

Section IV. Schedule of Benefits

Benefits are subject to all provisions of the Group Medical Coverage Agreement, including, without limitation, the Accessing Care provisions and General Exclusions. Members must refer to Section II., the Allowances Schedule, for Cost Shares and specific benefit limits that apply to benefits listed in this Schedule of Benefits. Members are entitled to receive only benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by GHC's Medical Director, or his/her designee, and as described herein. All Covered Services are subject to case management and utilization review at the discretion of GHC.

A. Hospital Care

Hospital coverage is limited to the following services:

1. Room and board, including private room when prescribed, and general nursing services.
2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).
3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Coverage must be authorized in advance by GHC as appropriate and

Medically Necessary. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.

4. Drugs and medications administered during confinement.
5. Special duty nursing, when prescribed as Medically Necessary.

If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility, upon consultation between a GHC Provider and the attending physician. If the Member refuses to transfer, all further costs incurred during the hospitalization are the responsibility of the Member.

B. Medical and Surgical Care

Medical and surgical coverage is limited to the following:

1. Surgical services.
2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services.
3. Family planning counseling services.
4. Hearing examinations to determine hearing loss.

Hearing aid examinations, hearing aids and fittings when authorized by a GHC Provider.

Excluded:

- a. Replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the limitation set forth in the Allowances Schedule.
 - b. Replacement parts, replacement batteries and maintenance costs.
5. Blood and blood derivatives and their administration.
 6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHC. Preventive care includes: routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHC, and immunizations and vaccinations listed as covered in the GHC drug formulary (approved drug list). A fee may be charged for health education programs. The well care schedule is available in GHC clinics, by accessing GHC's website at www.ghc.org, or upon request.

Covered Services provided during a preventive care visit, which are not in accordance with the GHC well care schedule, are subject to the applicable Cost Shares.

7. Radiation therapy services.
8. Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts.
9. Medical implants.

Excluded: internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by GHC's Medical Director, or his/her designee.

10. Respiratory therapy.

11. Outpatient total parenteral nutritional therapy; outpatient elemental formulas for malabsorption; and dietary formula for the treatment of phenylketonuria (PKU). Coverage for PKU formula is not subject to a Pre-Existing Condition waiting period, if applicable.

Equipment and supplies for the administration of enteral and parenteral therapy are covered under Devices, Equipment and Supplies.

Excluded: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

12. Visits with GHC Providers, including consultations and second opinions, in the hospital or provider's office.
13. Optical services.

Routine eye examinations and refractions received at a GHC Facility once every twelve (12) months, except when Medically Necessary.

When dispensed through GHC Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery performed by a GHC Provider, provided the Member has been continuously covered by GHC since such surgery. Replacement of a covered contact lens will be covered only when needed due to a change in the Member's Medical Condition, but no more than once in a twelve (12) month period.

Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures, and contact lens fittings and related examinations, except as set forth above.

14. Maternity care, including care for complications of pregnancy and prenatal and postpartum visits.

Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by GHC's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.

Hospitalization and delivery, including home births for low risk pregnancies. Planned home births must be authorized in advance by GHC.

Voluntary (not medically indicated and nontherapeutic) or involuntary termination of pregnancy.

The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery. Pregnancy will not be excluded as a Pre-Existing Condition under the Agreement. Treatment for post-partum depression or psychosis is covered only under the mental health benefit.

Excluded: birthing tubs and genetic testing of non-Members for the detection of congenital and heritable disorders.

15. Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following:
 - a. Evaluation testing to determine recipient candidacy,
 - b. Matching tests,
 - c. Inpatient and outpatient medical expenses listed below for transplantation procedures. Covered Services must be directly associated with, and occur at the time of, the transplant. The following transplantation expenses are covered as set forth in the Allowances Schedule:
 - Hospital charges,
 - Procurement center fees,

- Professional fees,
- Travel costs for a surgical team,
- Excision fees, and
- Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees.

- d. Follow-up services for specialty visits,
- e. Rehospitalization, and
- f. Maintenance medications.

Excluded: donor costs to the extent that they are reimbursable by the organ donor's insurance, treatment of donor complications, living expenses and transportation expenses, except as set forth under Section IV.M.

16. Manipulative therapy.

Self-Referrals for manipulative therapy of the spine and extremities are covered as set forth in the Allowances Schedule when provided by GHC Providers.

Excluded: supportive care rendered primarily to maintain the level of correction already achieved, care rendered primarily for the convenience of the Member, care rendered on a non-acute, asymptomatic basis and charges for any other services that do not meet GHC clinical criteria as Medically Necessary.

17. Medical and surgical services and related hospital charges, including orthognathic (jaw) surgery, for the treatment of temporomandibular joint (TMJ) disorders. Such disorders may exhibit themselves in the form of pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food. TMJ appliances are covered as set forth under Section IV.H.1., Orthopedic Appliances.

Orthognathic (jaw) surgery for the treatment of TMJ disorders, radiology services and TMJ specialist services, including fitting/adjustment of splints are subject to the benefit limit set forth in the Allowances Schedule.

Excluded are the following: orthognathic (jaw) surgery in the absence of a TMJ or severe obstructive sleep apnea diagnosis except for congenital anomalies, treatment for cosmetic purposes, dental services, including orthodontic therapy and any hospitalizations related to these exclusions.

18. Diabetic training and education.

19. Detoxification services for alcoholism and drug abuse.

For the purposes of this section, "acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Member for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health.

Coverage for acute chemical withdrawal is provided without prior approval. If a Member is hospitalized in a non-GHC Facility/program, coverage is subject to payment of the Emergency Deductible. The Member or person assuming responsibility for the Member must notify GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible. Furthermore, if a Member is hospitalized in a non-GHC Facility/program, GHC reserves the right to require transfer of the Member to a GHC Facility/program upon consultation between a GHC Provider and the attending physician. If the Member refuses transfer to a GHC Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.

20. Circumcision.

21. Nutritional counseling provided by GHC staff.

22. Sterilization procedures.

23. General anesthesia services and related facility charges for dental procedures will be covered for Members who are under seven (7) years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office. Such services must be authorized in advance by GHC and performed at a GHC hospital or ambulatory surgical facility.

Excluded: dentist's or oral surgeon's fees.

24. Self-Referrals to GHC acupuncturists and naturopaths for Covered Services, as set forth in the Allowances Schedule. Additional visits are covered when approved by GHC. Laboratory and radiology services are covered only when obtained through a GHC Facility.

Excluded: herbal supplements, preventive care visits to acupuncturists and any services not within the scope of their licensure.

25. Once Pre-Existing Condition wait periods, if any, have been met, Pre-Existing Conditions are covered in the same manner as any other illness.

C. Chemical Dependency Treatment.

Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted.

For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning.

Chemical dependency treatment services are covered as set forth below at a GHC Facility or GHC-approved treatment program, subject to the benefit period Allowance set forth in the Allowances Schedule. Any Cost Shares for chemical dependency services under the terms of the Agreement shall not be applied toward the benefit period Allowance.

1. **Chemical Dependency Treatment Services.** All alcoholism and/or drug abuse treatment services must be: (a) provided at a facility as described above; and (b) deemed Medically Necessary as defined above. Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines.

Court-ordered treatment shall be covered only if determined to be Medically Necessary as defined above.

2. **Benefit Period.** For the purposes of this section, "benefit period" shall mean a twenty-four (24) consecutive calendar month period during which the Member is eligible to receive covered chemical dependency treatment services, as set forth in this section. The first benefit period shall begin on the first day the Member receives covered chemical dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under the Agreement remains in force. All subsequent benefit periods thereafter will begin on the first day Covered Services are received after the expiration of the previous twenty-four (24) month benefit period.

D. Plastic and Reconstructive Services. Plastic and reconstructive services are covered as set forth below:

1. Correction of a congenital disease or congenital anomaly, as determined by a GHC Provider. A congenital anomaly will be considered to exist if the Member's appearance resulting from such condition is not within the range of normal human variation.
2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHC which has produced a major effect on the Member's appearance, when in the opinion of a GHC Provider, such services can reasonably be expected to correct the condition.

3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

Members will be covered for all stages of reconstruction on the non-diseased breast to make it equivalent in size with the diseased breast.

Complications of covered mastectomy services, including lymphedemas, are covered.

Excluded: complications of noncovered surgical services.

E. Home Health Care Services. Home health care services, as set forth in this section, shall be covered when provided by and referred in advance by a GHC Provider for Members who meet the following criteria:

1. The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.
2. The Member requires intermittent skilled home health care services, as described below.
3. A GHC Provider has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

For the purposes of this section, "skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.

Covered Services for home health care may include the following when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy, durable medical equipment and medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services.

Excluded: custodial care and maintenance care, private duty or continuous nursing care in the Member's home, housekeeping or meal services, care in any nursing home or convalescent facility, any care provided by or for a member of the patient's family and any other services rendered in the home which do not meet the definition of skilled home health care above or are not specifically listed as covered under the Agreement.

F. Hospice Care. Hospice care is covered in lieu of curative treatment for terminal illness for Members who meet all of the following criteria:

- A GHC Provider has determined that the Member's illness is terminal and life expectancy is six (6) months or less.
- The Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness).
- The Member has elected in writing to receive hospice care through GHC's Hospice Program or GHC's approved hospice program.
- The Member has available a primary care person who will be responsible for the Member's home care.
- A GHC Provider and GHC's Hospice Director, or his/her designee, have determined that the Member's illness can be appropriately managed in the home.

Hospice care shall mean a coordinated program of palliative and supportive care for dying Members by an interdisciplinary team of professionals and volunteers centering primarily in the Member's home.

1. **Covered Services.** Care may include the following as prescribed by a GHC Provider and rendered pursuant to an approved hospice plan of treatment:

- a. **Home Services**

- i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
- ii. Continuous care services in the Member's home when prescribed by a GHC Provider, as set forth in this paragraph. "Continuous care" means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Member at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a GHC Provider determines that the Member would otherwise require hospitalization in an acute care facility.

b. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered in a facility designated by GHC's Hospice Program or GHC-approved hospice program when authorized in advance by a GHC Provider and GHC's Hospice Program or GHC-approved hospice program.

Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence in order to continue care for the Member in the temporary absence of the Member's primary care giver(s).

- c. Other covered hospice services may include the following:
 - i. Drugs and biologicals that are used primarily for the relief of pain and symptom management.
 - ii. Medical appliances and supplies primarily for the relief of pain and symptom management.
 - iii. Durable medical equipment.
 - iv. Counseling services for the Member and his/her primary care-giver(s).
 - v. Bereavement counseling services for the family.

2. Hospice Exclusions. All services not specifically listed as covered in this section are excluded, including:

- a. Financial or legal counseling services.
- b. Meal services.
- c. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
- d. Services not specifically listed as covered by the Agreement.
- e. Any services provided by members of the patient's family.

All other exclusions listed in Section V., General Exclusions, apply.

G. Rehabilitation Services.

- 1. Rehabilitation services are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; and speech therapy to restore function following illness, injury or surgery. Services are subject to all terms, conditions and limitations of the Agreement, including the following:
 - a. All services must be provided at a GHC or GHC-approved rehabilitation facility and must be prescribed and provided by a GHC-approved rehabilitation team that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.
 - b. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when GHC's Medical Director, or his/her designee, determines that significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.
 - c. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs not provided by GHC; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is

made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning (except as set forth in subsection 2. below); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

- 2. Neurodevelopmental Therapies for Children Age Six (6) and Under.** Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member's condition would result without the services. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: specialty rehabilitation programs not provided by GHC; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

H. Devices, Equipment and Supplies.

Devices, equipment and supplies, which restore or replace functions that are common and necessary to perform basic activities of daily living, are covered as set forth in the Allowances Schedule. Examples of basic activities of daily living are dressing and feeding oneself, maintaining personal hygiene, lifting and gripping in order to prepare meals and carrying groceries.

- 1. Orthopedic Appliances.** Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

- 2. Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.
- 3. Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHC, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.
- 4. Prosthetic Devices.** Prosthetic devices are items which replace all or part of an external body part, or function thereof.

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: items which are not necessary to restore or replace functions of basic activities of daily living; and replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

I. Tobacco Cessation. When provided through GHC, services related to tobacco cessation are covered, limited to:

1. participation in one individual or group program per calendar year;
2. educational materials; and
3. approved pharmacy products provided the Member is actively participating in a GHC-designated tobacco cessation program.

J. Drugs, Medicines, Supplies and Devices. This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Eligible Members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the Agreement and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date.

The Agreement may include Medicare Part D pharmacy benefits as part of the GHC Medicare Advantage Plan required for Medicare eligible Members who live in the GHC Medicare Advantage Service Area. See Section III.D. for more information. A Member who discontinues coverage under the Agreement must meet eligibility requirements in order to re-enroll.

Legend medications are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services), contraceptive drugs and devices and their fitting, diabetic supplies, including insulin syringes, lancets, urine-testing reagents, blood-glucose monitoring reagents and insulin, are covered as set forth below.

All drugs, supplies, medicines and devices must be prescribed by a GHC Provider for conditions covered by the Agreement, obtained at a GHC pharmacy and, unless approved by GHC in advance, be listed in the GHC drug formulary. The prescription drug Cost Share, as set forth in the Allowances Schedule, applies to each thirty (30) day supply. Cost Shares for single and multiple thirty (30) day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the prescription drug Cost Share. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by GHC. A limited supply of prescription drugs obtained at a non-GHC pharmacy is covered when dispensed or prescribed in connection with covered Emergency treatment.

Generic drugs will be dispensed whenever available. Brand name drugs will be dispensed if there is not a generic equivalent. In the event the Member elects to purchase brand-name drugs instead of the generic equivalent (if available), or if the Member elects to purchase a different brand-name or generic drug than that prescribed by the Member's Provider, and it is not determined to be Medically Necessary, the Member will also be subject to payment of the additional amount above the applicable pharmacy Cost Share set forth in the Allowances Schedule. A generic drug is defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. A brand name drug is defined as a prescription drug that has been patented and is only available through one manufacturer.

"Standard reference compendia" means the American Hospital Formulary Service-Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia-Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in healthcare journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; vitamins, including Legend (prescription) vitamins; and any other drugs, medicines and injections not listed as covered in the GHC drug formulary unless approved in advance by GHC as Medically Necessary.

The Member will be charged for replacing lost or stolen drugs, medicines or devices.

The Member's Right to Safe and Effective Pharmacy Services.

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered under the Agreement and what coverage limitations are in the Agreement.

Members who would like more information about the drug coverage policies under the Agreement, or have a question or concern about their pharmacy benefit, may contact GHC at (206) 901-4636 or (888) 901-4636.

Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Agreement, may contact the Washington State Office of Insurance Commissioner at (800) 562-6900. Members who have a concern about the pharmacists or pharmacies serving them, may call the Washington State Department of Health at (800) 525-0127.

K. Mental Health Care Services. Services that are provided by a mental health practitioner will be covered as mental health care, regardless of the cause of the disorder.

- 1. Outpatient Services.** Outpatient mental health services place priority on restoring the Member to his/her level of functioning prior to the onset of acute symptoms or to achieve a clinically appropriate level of stability as determined by GHC's Medical Director, or his/her designee. Treatment for clinical conditions may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.

Coverage for each Member is provided according to the outpatient mental health care Allowance set forth in the Allowances Schedule. Psychiatric medical services, including medical management and prescriptions, are covered as set forth in Sections IV.B. and IV.J.

- 2. Inpatient Services.** Charges for services described in this section, including psychiatric Emergencies resulting in inpatient services, shall be covered up to the maximum benefit set forth in the Allowances Schedule. This benefit shall include coverage for acute treatment and stabilization of psychiatric Emergencies in GHC-approved hospitals. When medically indicated, outpatient electro-convulsive therapy (ECT) is covered in lieu of inpatient services. Coverage for services incurred at non-GHC Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a GHC Facility.

Partial hospitalization is covered subject to the maximum inpatient benefit limit described in the Allowances Schedule. Every two (2) partial hospitalization days are equivalent to one inpatient hospital day. The total maximum annual benefit under this section shall not exceed the number of inpatient days described in the Allowances Schedule.

Subject to the maximum inpatient mental health care Allowance set forth in the Allowances Schedule, services provided under involuntary commitment statutes shall be covered at facilities approved by GHC. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary by GHC's Medical Director, or his/her designee.

Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit set forth in Section IV.L., including the twenty-four (24) hour notification and transfer provisions.

Outpatient electro-convulsive therapy treatment is covered subject to the outpatient surgery Cost Share.

- 3. Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.** Covered Services are limited to those authorized by GHC's Medical Director, or his/her designee, for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention.

Partial hospitalization programs are covered only under subsection K.2. (Inpatient Services).

Excluded: learning, communication and motor skills disorders; mental retardation; academic or career counseling; sexual and identity disorders; and personal growth or relationship enhancement. Also excluded: assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating; nicotine related disorders; relationship counseling or phase of life problems (V code only diagnoses); and custodial care.

Any other services not specifically listed as covered in this section. All other provisions, exclusions and limitations under the Agreement also apply.

L. Emergency/Urgent Care.

All services are covered subject to the Cost Shares set forth in the Allowances Schedule.

Emergency Care (See Section VIII. for a definition of Emergency.)

1. **At a GHC Facility.** GHC will cover Emergency care for all Covered Services.
2. **At a Non-GHC Facility.** Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:
 - a. Payment of the Emergency care *Copayment*; and
 - b. Notification of GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.
3. **Waiver of Emergency Care Cost Share.**
 - a. **Waiver for Multiple Injury Accident.** If two or more Members in the same Family Unit require Emergency care as a result of the same accident, coverage for all Members will be subject to only one (1) Emergency care Cost Share.
 - b. **Emergencies Resulting in an Inpatient Admission.** If the Member is admitted to a GHC Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Cost Share.
4. **Transfer and Follow-up Care.** If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility, upon consultation between a GHC Provider and the attending physician. If the Member refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

Follow-up care which is a direct result of the Emergency must be obtained from GHC Providers, unless a GHC Provider has authorized such follow-up care from a non-GHC Provider in advance.

Urgent Care (See Section VIII. for a definition of Urgent Condition.)

Inside the GHC Service Area, care for Urgent Conditions is covered only at GHC medical centers, GHC urgent care clinics or GHC Providers' offices, subject to the applicable Cost Share. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider.

Outside the GHC Service Area, Usual, Customary and Reasonable charges are covered for Urgent Conditions received at any medical facility, subject to the applicable Cost Share.

M. Ambulance Services. Ambulance services are covered as set forth below, provided that the service is authorized in advance by a GHC Provider or meets the definition of an Emergency (see Section VIII.).

1. **Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule.
2. **Interfacility Transfers.** GHC-initiated non-emergent transfers to or from a GHC Facility are covered as set forth in the Allowances Schedule.

N. Skilled Nursing Facility (SNF). Skilled nursing care in a GHC-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending GHC Provider, is covered as set forth in the Allowances Schedule.

When prescribed by a GHC Provider, such care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy and restorative speech therapy.

Excluded: personal comfort items such as telephone and television, rest cures and custodial, domiciliary or convalescent care.

Section V. General Exclusions

In addition to exclusions listed throughout the Agreement, the following are not covered:

1. Services or supplies not specifically listed as covered in the Schedule of Benefits, Section IV.
2. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; take-home drugs, dressings and supplies following hospitalization; and any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section IV.
3. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided in Section IV.D.
4. Convalescent or custodial care.
5. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.E., IV.F. or IV.H.
6. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.
7. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHC for early detection of disease.
8. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.
9. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.
10. Any services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

The Member and his/her agents must cooperate fully with GHC in its efforts to enforce this exclusion. This cooperation shall include supplying GHC with information about, or related to, the availability of other insurance coverage. The Member and his/her agent shall permit GHC, at GHC's option, to associate with the Member or to intervene in any action filed against any party related to the injury. The Member and his/her agents shall do nothing to prejudice GHC's right to enforce this exclusion. In the event the Member fails to cooperate fully, GHC reserves the right to deny coverage and the Member shall be responsible for reimbursing GHC for such medical expenses.

GHC shall not enforce this exclusion as to coverage available under uninsured motorist or underinsured motorist coverage until the Member has been made whole, unless the Member fails to cooperate fully with GHC as described above.

GHC shall not pay any attorneys' fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHC prior to any collection efforts. Under no circumstances will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHC.

11. Voluntary (not medically indicated and nontherapeutic) termination of pregnancy, unless otherwise noted in Section IV.B.
12. The cost of services and supplies resulting from a Member's loss of or willful damage to appliances, devices, supplies and materials covered by GHC for the treatment of disease, injury or illness.
13. Orthoptic therapy (i.e., eye training).
14. Specialty treatment programs such as weight reduction, "behavior modification programs" and rehabilitation, including cardiac rehabilitation.
15. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.
16. Nontherapeutic sterilization, unless otherwise noted in Section IV.B., and procedures and services to reverse a therapeutic or nontherapeutic sterilization.
17. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental service not specifically listed as covered in Section IV. GHC's Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service.
18. Drugs, medicines and injections, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injections, including those not listed as covered in the GHC drug formulary (approved drug list), will also exclude their administration.
19. Experimental or investigational services.

GHC consults with GHC's Medical Director and then uses the criteria described below to decide if a particular service is experimental or investigational.

- a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member.
 - i. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
 - ii. The service is the subject of a current new drug or new device application on file with the FDA.
 - iii. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service.
 - iv. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
 - v. The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
 - vi. The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.

- vii. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.
- b. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
- i. The Member's medical records,
 - ii. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
 - iii. Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
 - iv. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
 - v. The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
 - vi. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding denial of coverage can be submitted to the Member Appeals Department, or to GHC's Medical Director at P.O. Box 34593, Seattle, WA 98124-1593. GHC will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Member's life or health.

- 20. Mental health care, except as specifically provided in Section IV.K.
- 21. Hypnotherapy, and all services related to hypnotherapy.
- 22. Genetic testing and related services, unless determined Medically Necessary by GHC's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in Section IV.B. Testing for non-Members is also excluded.
- 23. Follow-up visits related to a non-Covered Service.
- 24. Fetal ultrasound in the absence of medical indications.
- 25. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.
- 26. Complications of non-Covered Services.
- 27. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth in Section IV.B.
- 28. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a member of the Member's family.
- 29. Autopsy and associated expenses.
- 30. Services provided by government agencies, except as required by federal or state law.
- 31. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.
- 32. Services covered by the national health plan of any other country.

33. Pre-Existing Conditions, except as specifically provided in Section IV.B.25.

Section VI. Grievance Processes for Complaints and Appeals

The grievance processes to express a complaint and appeal a denial of benefits are set forth below.

Filing a Complaint or Appeal

The complaint process is available for a Member to express dissatisfaction about customer service or the quality or availability of a health service.

The appeals process is available for a Member to seek reconsideration of a denial of benefits.

Complaint Process

Step 1: The Member should contact the person involved, explain his/her concerns and what he/she would like to have done to resolve the problem. The Member should be specific and make his/her position clear.

Step 2: If the Member is not satisfied, or if he/she prefers not to talk with the person involved, the Member should call the department head or the manager of the medical center or department where he/she is having a problem. That person will investigate the Member's concerns. Most concerns can be resolved in this way.

Step 3: If the Member is still not satisfied, he/she should call the GHC Customer Service Center toll free at (888) 901-4636. Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. A Customer Service Representative or Member Quality of Care Coordinator will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to thirty (30) days to resolve after receipt of the Member's written statement.

If the Member is dissatisfied with the resolution of the complaint, he/she may contact the Member Quality of Care Coordinator or the Customer Service Center.

Appeals Process

Step 1: If the Member wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. If the Member is located west of the Cascade Mountains, appeals should be directed to GHC's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, (206) 901-7350 or toll free (866) 458-5479; or if the Member is located east of the Cascade Mountains, to GHC's Member Appeals Department, P.O. Box 204, Spokane, WA 99210-0204, (509) 241-7622 or toll free (866) 458-5479.

An Appeals Coordinator will review initial appeal requests. GHC will then notify the Member of its determination or need for an extension of time within fourteen (14) days of receiving the request for appeal. Under no circumstances will the review timeframe exceed thirty (30) days without the Member's written permission.

If the appeal request is for an experimental or investigational exclusion or limitation, GHC will make a determination and notify the Member in writing within twenty (20) working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GHC will notify the Member in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed twenty (20) days without the Member's written permission.

There is an expedited appeals process in place for cases which meet criteria or where the Member's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited appeal in writing to the above address, or by calling GHC's Member Appeals Department in western Washington at (206) 901-7350 or toll free (866) 458-5479, or in eastern Washington at (509)

241-7622 or toll free (866) 458-5479. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

Step 2: If the Member is not satisfied with the decision in Step 1 regarding a denial of benefits, or if GHC fails to grant or reject the Member's request within the applicable required timeframe, he/she may request a second level review by an external independent review organization as set forth under subsection A. below. The Member may also choose to pursue review by an appeals committee prior to requesting a review by an independent review organization as set forth under subsection B. below. This is not a required step in the appeals process.

A. Request a review by an independent review organization. An independent review organization is not legally affiliated or controlled by GHC. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through GHC. *

A request for a review by an independent review organization must be made within 180 days after the date of the Step 1 decision notice, or within 180 days after the date of a GHC appeals committee decision notice.

B. Request an optional hearing by the GHC appeals committee:

The appeals committee hearing is an informal process. The hearing will be conducted within thirty (30) working days of the Member's request and notification of the appeal committee's decision will be mailed to the Member within five (5) working days of the hearing.

Members electing the appeals committee maintain their right to appeal further to an independent review organization as set forth in paragraph A. above.

Review by the appeals committee is not available if the appeal request is for an experimental or investigational exclusion or limitation.

A request for a hearing by the appeals committee must be made within thirty (30) days after the date of the Step 1 decision notice.

If the Member is located west of the Cascade Mountains, the request can be mailed to GHC's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, or if the Member is located east of the Cascade Mountains, to GHC's Member Appeals Department, P.O. Box 204, Spokane, WA 99210-0204. *

* If the Member's health plan is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health plans, other than those sponsored by governmental entities or churches – ask employer about plan), the Member has the right to file a lawsuit under Section 502(a) of ERISA to recover benefits due to the Member under the plan at any point after completion of Step 1 of the appeals process. Members may have other legal rights and remedies available under state or federal law.

Section VII. General Provisions

A. Coordination of Benefits

The coordination of benefits (COB) provision applies when a Member has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the Member is covered by more than one health benefit plan, the Member or the Member's provider should file all the Member's claims with each plan at the same time. If Medicare is the Member's primary plan, Medicare may submit the Member's claims to the Member's secondary carrier.

1. Definitions.

a. **Plan.** A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- 1) Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- 2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

Each contract for coverage under subsection 1) or 2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

- b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- c. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Member has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered Member. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

d. **Allowable Expense.** Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

- 1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- 2) If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method,

any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

- 3) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- f. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

2. Order of Benefit Determination Rules.

When a Member is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- b. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the Subscriber. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- c. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- d. Each plan determines its order of benefits using the first of the following rules that apply:
 - 1) Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Member as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent, and primary to the plan covering the Member as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.
 - 2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;

- (2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - (3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
 - (4) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits; or
 - (5) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent, first;
 - The plan covering the spouse of the custodial parent, second;
 - The plan covering the non-custodial parent, third; and then
 - The plan covering the spouse of the non-custodial parent, last.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.
- 3) Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.
 - 4) COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Subscriber or retiree or covering the Member as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.
 - 5) Longer or shorter length of coverage. The plan that covered the Member as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.
 - 6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

3. Effect on the Benefits of this Plan.

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expenses for that claim. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. GHC may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans

covering the Member claiming benefits. GHC need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this plan must give GHC any facts it needs to apply those rules and determine benefits payable.

5. Facility of Payment.

If payments that should have been made under this plan are made by another plan, GHC has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, GHC is fully discharged from liability under this plan.

6. Right of Recovery.

GHC has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. GHC may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits? Contact the State Insurance Department.

7. Effect of Medicare.

Members Residing Outside the GHC Medicare Advantage Service Area. Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status.

When GHC renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare primary/secondary payer guidelines and regulations, GHC will seek Medicare reimbursement for all Medicare covered services.

B. Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If GHC provides benefits under this Agreement for the treatment of the injury or illness, GHC will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness. This section VII.B. more fully describes GHC's subrogation and reimbursement rights.

"Injured Person" under this section means a Member covered by the Agreement who sustains an injury and any spouse, dependent or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "GHC's Medical Expenses" means the expenses incurred and the reasonable value of the benefits provided by GHC for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHC shall have the right to recover GHC's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." GHC shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHC's Medical Expenses.

GHC's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages. However, in the case of Medicare Advantage Members, GHC's right of subrogation shall be the full amount of GHC's Medical Expenses and is limited only as required by Medicare.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorist funds, then GHC's Medical Expenses provided or to be provided to the Injured Person are secondary, not primary. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHC

services is constructive notice of this provision in its entirety and agrees to reimburse GHC for the benefits the Injured Person received as a result of the events causing the injury.

The Injured Person and his/her agents shall cooperate fully with GHC in its efforts to collect GHC's Medical Expenses. This cooperation includes, but is not limited to, supplying GHC with information about any third parties, defendants and/or insurers related to the Injured Person's claim and informing GHC of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHC, at GHC's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHC to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHC's Medical Expenses.

The Injured Person and his/her agents shall do nothing to prejudice GHC's subrogation and reimbursement rights. The Injured Person shall promptly notify GHC of any tentative settlement with a third party and shall not settle a claim without protecting GHC's interest. If the Injured Person fails to cooperate fully with GHC in recovery of GHC's Medical Expenses, the Injured Person shall be responsible for directly reimbursing GHC for GHC's Medical Expenses and GHC retains the right to bill the Injured Person directly for GHC's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in their possession until GHC's subrogation and reimbursement rights are fully determined.

GHC shall not pay any attorneys' fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by GHC prior to any collection efforts. When reasonable collection costs have been incurred with GHC's prior written agreement to recover GHC's Medical Expenses, there shall be an equitable apportionment of such collection costs between GHC and the Injured Person subject to a maximum responsibility of GHC equal to one-third of the amount recovered on behalf of GHC. Under no circumstance will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery, which do not benefit GHC or where no written fee agreement has been entered into with GHC.

To the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration under the Agreement and GHC shall therefore have sole discretion to interpret its terms.

C. Miscellaneous Provisions

- 1. Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under the Agreement.
- 2. Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of the Agreement. *This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.*
- 3. Modification of Agreement.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Agreement, convey or void any coverage, increase or reduce any benefits under the Agreement or be used in the prosecution or defense of a claim under the Agreement.
- 4. Confidentiality.** GHC and the Group shall keep Member information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.
- 5. Nondiscrimination.** GHC does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

Section VIII. Definitions

Agreement: The Medical Coverage Agreement between GHC and the Group.

Allowance: The maximum amount payable by GHC for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Contracted Network Pharmacy: A pharmacy that has contracted with GHC to provide covered legend (prescription) drugs and medicines for outpatient use under the Agreement.

Copayment: The specific dollar amount a Member is required to pay at the time of service for certain Covered Services under the Agreement, as set forth in the Allowances Schedule.

Cost Share: The portion of the cost of Covered Services the Member is liable for under the Agreement. Cost Shares for specific Covered Services are set forth in the Allowances Schedule. Cost Share includes Copayments, coinsurances and/or Deductibles.

Covered Services: The services for which a Member is entitled to coverage under the Agreement.

Deductible: A specific amount a Member is required to pay for certain Covered Services before benefits are payable under the Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

Dependent: Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium prescribed in the Premium Schedule has been paid.

Emergency: The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health in serious jeopardy.

Family Unit: A Subscriber and all his/her Dependents.

Fee Schedule: A fee-for-service schedule adopted by GHC, setting forth the fees for medical and hospital services.

GHC-Designated Self-Referral Specialist: A GHC specialist specifically identified by GHC to whom Members may self-refer.

GHC Facility: A facility (hospital, medical center or health care center) owned, operated or otherwise designated by GHC.

GHC Medicare Plan: A plan of coverage for persons enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance).

GHC Personal Physician: A provider who is employed by or contracted with GHC to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which a Member can access without a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.

GHC Provider: The medical staff, clinic associate staff and allied health professionals employed by GHC, and any other health care professional or provider with whom GHC has contracted to provide health care services to Members enrolled under the Agreement, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Group: An employer, union, welfare trust or bona-fide association which has entered into a Group Medical Coverage Agreement with GHC.

Hospital Care: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care, which can, in the opinion of the GHC Provider, be provided by a nursing home or convalescent care center.

Lifetime Maximum: The maximum value of benefits provided for Covered Services under the Agreement after which benefits under the Agreement are no longer available as set forth in the Allowances Schedule. The value of Covered Services is based on the Fee Schedule, as defined above. The lifetime maximum applies to this Agreement or in combination with any other medical coverage agreement between GHC and Group.

Medical Condition: A disease, illness or injury.

Medically Necessary: Appropriate and clinically necessary services, as determined by GHC's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under GHC's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by GHC's Medical Director, or his/her designee. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service as set forth in Section IV. of the Agreement and not excluded from coverage. The cost of non-covered services and supplies shall be the responsibility of the Member.

Medicare: The federal health insurance program for the aged and disabled.

Member: Any Subscriber or Dependent enrolled under the Agreement.

Out-of-Pocket Expenses: Those Cost Shares paid by the Subscriber or Member for Covered Services which are applied to the Out-of-Pocket Limit.

Out-of-Pocket Limit: The maximum amount of Out-of-Pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and his/her Dependents within the same calendar year. The Out-of-Pocket Limit amount and Cost Shares that apply are set forth in the Allowances Schedule. Charges in excess of UCR, services in excess of any benefit level and services not covered by the Agreement are not applied to the Out-of-Pocket Limit.

Plan Coinsurance: The percentage amount the Member and GHC are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule.

Pre-Existing Condition: A condition for which there has been diagnosis, treatment or medical advice within the three (3) month period prior to the effective date of coverage. The Pre-Existing Condition wait period will begin on the first day of coverage, or the first day of the enrollment waiting period if earlier.

Referral: A written temporary agreement requested in advance by a GHC Provider and approved by GHC that entitles a Member to receive Covered Services from a specified health care provider. Entitlement to such services shall not exceed the limits of the Referral and is subject to all terms and conditions of the Referral and the Agreement. Members who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services.

Self-Referred: Covered Services received by a Member from a designated women's health care specialist or GHC-Designated Self-Referral Specialist that are not referred by a GHC Personal Physician.

Service Area: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by GHC.

Subscriber: A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled under the Agreement and for whom the premium specified in the Premium Schedule has been paid.

Urgent Condition: The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within twenty-four (24) hours of its onset.

Usual, Customary and Reasonable (UCR): A term used to define the level of benefits which are payable by GHC when expenses are incurred from a non-GHC Provider. Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.

EMPLOYER GROUP PROGRAMS

GROUP MEDICARE COVERAGE

Group Health Cooperative Medicare Advantage Prescription Drug Plan (GHMA-PD Plan)

Following is a brief outline of the benefits available to group Members who are also enrolled in the Group Health Cooperative Medicare Advantage Prescription Drug Plan. A more detailed plan summary is provided to GH-MAPD Plan members directly.

In no event shall the benefits of the GH-MAPD plan duplicate the medical benefits under the Group Medical Coverage Agreement. The benefits available to persons enrolled in both the Group Health Cooperative Medical Coverage Agreement and the Group Health Cooperative Medicare Advantage Prescription Drug Plan will be the higher level of benefit available under the plans, as determined by Group Health Cooperative.

Except for Members who have been certified by CMS for low income subsidy, the benefit for Medicare Part D eligible drugs will be the employer group plan benefit, as set forth in the Group Medical Coverage Agreement.

Unless otherwise stated, the provisions, limitations and exclusions, including provider access requirements of the Group Medical Coverage Agreement apply to the benefits available under the Group Health Medicare Advantage Plan.

The benefits described in this outline apply only to members who are covered under Medicare Part A, Part B and Part D, and who are enrolled in the Group Health Cooperative Medicare Advantage Prescription Drug Plan (MAPD) as set forth in the Group Medical Coverage Agreement. This includes those Members with Medicare Part B only, who have been continuously enrolled in the Group Health Cooperative Medicare Advantage Plan (formerly known as Medicare+Choice), since December 31, 1998.

SUMMARY OF BENEFITS

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
INPATIENT CARE		
<p>1 - Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period:</p> <p>Days 1 - 60: \$1,024 deductible. Days 61 - 90: \$256 per day. Days 91 - 150: \$512 per lifetime reserve day.</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network:</p> <p>For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments:</p> <p>Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>2 - Inpatient Mental Health Care</p>	<p>You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>	<p>For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments:</p> <p>Days 1-5: \$200 copay per day Days 6-90: \$0 copay per day</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p>

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
Inpatient Mental Health Care (cont.)		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
3 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>For each benefit period after at least a 3-day covered hospital stay:</p> <p>Days 1 - 20: \$0 per day. Days 21 - 100: \$128 per day.</p> <p>100 days for each benefit period.</p> <p>A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>There is no copayment for services received at a Skilled Nursing Facility.</p> <p>No prior hospital stay is required.</p> <p>You are covered for 100 days each benefit period.</p> <p>Prior authorization is required</p>
4 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	<p>Authorization rules may apply.</p> <p>\$0 copay for Medicare-covered home health visits.</p>
5 - Hospice	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>	You must receive care from a Medicare-certified hospice.

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
OUTPATIENT CARE		
6 - Doctor Office Visits	20% coinsurance	<p>General See “Routine Physical Exams” for more information.</p> <p>Authorization rules may apply.</p> <p>In-Network You pay the lesser of the Group cost share or \$20 copay for each primary care doctor office visit for Medicare-covered services.</p> <p>You pay the lesser of the Group cost share or \$20 copay for each specialist visit for Medicare-covered services.</p>
7 - Chiropractic Services	<p>20% coinsurance</p> <p>Routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractors or other qualified provider.</p> <p>You pay 100% for routine care.</p>	<p>In-Network You pay the lesser of the Group cost share or \$20 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>
8 - Podiatry Services	<p>20% coinsurance</p> <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>General Authorization rules may apply.</p> <p>In-Network You pay the lesser of the Group cost share or \$20 copay for Medicare-covered visits.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
9 - Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	In-Network You pay the lesser of the Group cost share or \$20 copay for each Medicare-covered individual or group therapy visit.
10 - Outpatient Substance Abuse Care	20% coinsurance	In-Network \$0 copay for Medicare-covered visit.
11 - Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility	General Authorization rules may apply. In-Network You pay the lesser of the Group cost share or \$200 for each Medicare-covered ambulatory surgical center visit. You pay the lesser of the Group cost share or \$200 for each Medicare-covered outpatient hospital facility visit.
12 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network You pay the lesser of the Group cost share or \$150 for Medicare-covered ambulance services.
13 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge or a set copay per emergency room visit. You don't have to pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.	In-Network You pay the lesser of the Group cost share or \$ 50 for each Medicare-covered emergency room visits. Out-of-Network Worldwide coverage.

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
Emergency Care (cont.)	NOT covered outside the U.S. except under limited circumstances.	In and Out-of-Network If you are admitted to the hospital within 1 day for the same condition, you pay \$0 for the emergency room visits.
14 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	You pay the lesser of the Group cost share or \$20 for each Medicare-covered urgently needed care visit.
15 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network You pay the lesser of the Group cost share or \$20 for Medicare-covered Occupational Therapy visits. You pay the lesser of the Group cost share or \$20 for Medicare-covered Physical Therapy and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
16 - Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered items.
17 - Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered items.

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
<p>18 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered Diabetes Supply items.</p>
<p>19 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and X-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • <i>lab services</i> • <i>diagnostic procedures and tests</i> • X-rays • Diagnostic radiology services (not including X-rays) • therapeutic radiology services
PREVENTIVE SERVICES		
<p>20 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay</p>
<p>21 - Colorectal Screening Exams (for people with Medicare age 50 and older)</p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>General Authorization rules may apply.</p>

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
Colorectal Screening Exams (cont.)		In-Network \$0 copay for Medicare-covered Colorectal Screenings.
22 - Immunizations (Flu vaccine, Hepatitis B vaccine for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information..	General Authorization rules may apply. In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine No referral necessary for Flu and Pneumonia vaccines. Referral required for other immunizations.
23 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network \$0 copay for Medicare-covered screening mammograms.
24 - Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap Smears once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for pelvic exams.	In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.
25 - Prostate Cancer Screening Exams (For men with Medicare age 50 and older.)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screenings.

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
<p>26 – ESRD</p>	<p>20% coinsurance for dialysis</p>	<p>General Authorization rules may apply.</p> <p>Out-of-area Renal Dialysis services do not require Authorization.</p> <p>In-Network \$0 copay for in and out-of-area dialysis</p> <p>\$0 copay for Nutrition Therapy for Renal Disease.</p>
<p>27 - Outpatient Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs covered under Part D (Prescription Drug Benefit)</p>	<p>Most drugs not covered.</p> <p>(You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan).</p>	<p>Your Employer Group Outpatient Prescription drug benefit applies.</p> <p>Please contact the plan for details.</p>
<p>28 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network Dental benefits not covered.</p>
<p>29 - Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>Your Employer Group benefit applies.</p>
<p>30 – Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>Your Employer Group benefit applies.</p>

Benefit Category	Original Medicare	GHC Medicare Employer Group Plan
31 - Physical Exams	20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage. The coverage does not include lab tests.	\$0 copay for routine exams.
Health/Wellness Education	Not covered	In-Network This plan covers health/wellness education benefits. - Smoking Cessation - Health Club Membership/Fitness Classes
Transportation (Routine)	Not covered	General Authorization rules may apply. In-Network \$150 copay for one-way trips to a Plan-approved location.
US Visitor/Traveler Benefit		Non-emergent and/or non-urgently needed care received while temporarily traveling outside GHC's Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per Member per calendar year. The GHC MA Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Member is responsible for all Medicare inpatient and outpatient Deductibles and Coinsurances. Member pays the lesser of the Group Cost Share or 20% of the cost for each stay in a non-network hospital or inpatient psychiatric hospital.

IMPORTANT INFORMATION ABOUT YOUR OUTPATIENT CARE APPEAL RIGHTS

For more information about your appeal rights, call us toll free at: 1-888-901-4636.

There Are Two Kinds of Appeals You Can File

Standard (30 days)- You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Fast (72 hour review)- You can ask for a fast appeal if you or your doctor believes that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, we will automatically give you a fast appeal.

If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service.

Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For a Standard Appeal: You or your authorized representative should mail or deliver your written appeal to the address (es) below:

MAIL: Group Health Cooperative
GHC Appeals Department
PO Box 34593
Seattle, WA 98124-1593
Attn.: Appeals' Coordinator

HAND DELIVER: 12400 E. Marginal Way South
Seattle, WA 98168-2559

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax: telephone: 206-901-7350, fax: 206-901-7340

What Happens Next? If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Advantage (formerly Medicare Plus Choice) Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Contact Information:

If you need information or help, call us at:

Toll Free: 1-888-901-4636

TTY/TTD: 1-800-833-6388

Other Resources To Help You:

Medicare Rights Center: 1-800-445-6941

Toll Free: 1-888-HMO-9050

TTY/TTD: 1-800-521-8890

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

IMPORTANT INFORMATION ABOUT YOUR HOSPITAL CARE APPEAL RIGHTS

For more information about your appeal rights, call us toll free at: 1-888-901-4636.

How Do You Get an Immediate Review?

QualisHealth is the name of the Quality Improvement Organization (QIO) authorized by Medicare to review the Hospital care provided to Medicare patients. You or your authorized representative, attorney, or court appointed guardian must contact the QIO by telephone or in writing:

QualisHealth - QIO
10700 Meridian Avenue
Seattle, WA 98133
Toll Free: 1-800-445-6941, option 2
Local: 206-364-9700
FAX: 206-368-2419
TTY: 1-800-251-8890

If you file a written request, please write, **“I want an immediate review”**.

Your request must be made no later than noon of the first working day after you receive this notice.

The QIO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.

While you remain in the Hospital, Group Health will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the QIO notifies you of its official Medicare coverage decision.

What If the QIO Agrees With Our Coverage Decision?

If the QIO agrees, you will be responsible for paying the cost of your hospital stay beginning at noon of the calendar day following the day the QIO notifies you of its Medicare coverage decision.

What If the QIO Disagrees With Our Coverage Decision?

You will not be responsible for paying the cost of your additional hospital days, except for certain convenience services or items not covered by your contract.

What If You Don't Request an Immediate Review?

If you remain in the hospital and do not request an immediate review by the QIO, you may be financially responsible for the cost of many of the services you receive beginning [specify the date of the first non-covered day].

If you leave before the day following the date of this notice you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your Health Plan.

What If You Are Late Or Miss the Deadline To File For an Immediate Review?

If you are late or miss the noon deadline to file for an immediate review by your QIO, you may still request an expedited (fast) appeal from Group Health. A “fast” appeal means Group Health will have to review your request within 72 hours. However, you will not have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your hospital stay beginning the day following the date of this notice.

For a Fast Appeal: You or your authorized representative should contact us by telephone or fax: telephone: 206-901-7350, fax: 206-901-7340

When you do so say or write: **“I want a fast appeal.”**

If you filed for an immediate QIO review but missed the deadline the QIO will forward the request to Group Health to process a fast appeal.

IMPORTANT INFORMATION ABOUT YOUR MEDICARE PART D APPEAL RIGHTS

For more information about your appeal rights, call us toll free at: 1-888-901-4636.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

If the doctor who prescribed the drug(s) asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, we will automatically expedite your appeal.

If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within 7 days.

Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days) - You can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited Appeal: You or your appointed representative should contact us by telephone or fax at the numbers below:

Phone: 206-901-7350

Fax: 206-901-7340

For a Standard Appeal: You or your appointed representative should mail or deliver your written appeal request to the address below:

Group Health Cooperative
GHC Appeals Department
PO Box 34593
Seattle, WA 98124-1593
Attn.: Appeals' Coordinator
12400 E. Marginal Way South
Seattle, WA 98168-2559

What Happens Next? If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information:

If you need information or help, call us at:

Toll Free: 1-888-901-4636

TTY/TTD: 1-800-833-6388

Other Resources To Help You:

Medicare Rights Center: 1-800-445-6941

Toll Free: 1-888-HMO-9050

TTY/TTD: 1-800-521-8890

Elder Care Locator

Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

TTY/TTD: 1-877-486-2048

PREMIUM SCHEDULE

Group Name	City of Seattle - Early Retirees		
Group Number (Primary/Secondary)	1004400/4911700		
GROUP HEALTH COOPERATIVE - Group Health benefit description			
Inside the Network: Managed Care Providers			
Coinsurance	None		
Deductible	None		
Emergency Copay	\$100/\$150		
Family Ded & OOP Max	2x		
Hospital Inpatient Copay	\$200/Per admit		
Office Visit Copay	\$15		
Optical Rider	Not covered		
Out Of Pocket	\$2000		
Outpatient Surgery Copay	Same as OV		
Prescription Drug Copay	\$15/\$30		
No PEC Wait		Group Offering	Dual Choice
MONTHLY HEALTHCARE PREMIUM			
<i>This Schedule reflects from: 01/01/2009 to 06/01/2009</i>			
Subscriber	\$394.93		
Spouse	\$394.93		
1st Child	\$230.01		
Each Additional Children	\$212.51		
HEALTH CARE DUES FOR MEMBERS WITH MEDICARE COVERAGE			
Medicare entitled with AB Medicare	\$169.20		



**2009 Medicare Endorsement
Group Health Cooperative Medicare Advantage Prescription Drug Plan**

This Endorsement does not constitute a “Medicare Supplemental” contract.

The provisions of the Group Medical Coverage Agreement shall remain in effect except as modified by the addition of the provisions, exclusions, and limitations contained in this Medicare Endorsement.

In no event shall the benefits under this Endorsement duplicate the medical benefits under the Group Medical Coverage Agreement. The benefits available to persons enrolled in both the Group Health Cooperative Medical Coverage Agreement and the Group Health Cooperative Medicare Advantage Prescription Drug Plan will be the higher level of benefit available under the plans as determined by Group Health.

Except for Members who have been certified by CMS for low income subsidy, the benefit for Medicare Part D eligible drugs will be the employer group plan benefit, as set forth in the Group Medical Coverage Agreement.

The benefits and exclusions described in this Endorsement apply only to members who are covered under Medicare Part A, Part B and Part D and who are enrolled in the Group Health Cooperative Medicare Advantage Prescription Drug Plan (MAPD) as set forth in Section III. D., of the Group Medical Coverage Agreement. This includes those members with Medicare Part B only, who have been continuously enrolled in the Group Health Cooperative Medicare Advantage Plan (formerly known as Medicare+Choice), since December 31, 1998 and are now enrolled in Medicare Part D.

Except as defined by federal regulations, all members entitled to, or eligible to purchase Medicare and who live in the Group Health Cooperative Medicare Advantage Plan service area, must enroll in the Group Health Cooperative Medicare Advantage Prescription Drug Plan upon such entitlement or eligibility.

Incorporated into this endorsement is the GHC Medicare Advantage Prescription Drug Plan Explanation of Coverage (EOC). The EOC sets forth the benefits, provisions and requirements of the GHC MAPD plan. The EOC document has been approved by The Centers for Medicare and Medicaid (CMS) Services.

MEDICARE PART D LOW INCOME SUBSIDY NOTICE

- A. The Low Income Subsidy (LIS) provisions of Subpart P of the final rule for the Medicare prescription drug benefit (423.771 et. seq.) apply to employer and union-sponsored Part D plans in the same manner as they apply to other Part D plans. For each beneficiary entitled to the LIS, the Centers for Medicare and Medicaid Services, [CMS] pays the beneficiary's premium (up to the low income premium subsidy amount) and cost sharing obligations minus the beneficiary's cost-sharing responsibilities under the LIS rules.
- B. CMS requires that the LIS premium subsidy that CMS is paying on behalf of the LIS eligible retiree be passed through to the retiree.
- C. The monthly premium subsidy amount for a beneficiary eligible for the low-income subsidy must first be used to reduce the portion of the monthly beneficiary premium paid for by the beneficiary, with any remainder then used to reduce the Group's premium contribution.

Now, therefore, the parties agree as follows:

- 1. GHC will identify the LIS-eligible retirees for the Group and provide that information to the Group.
- 2. If the low income premium subsidy amount is less than the beneficiary premium contribution under the plan, including any beneficiary premium contribution for supplemental benefits, the Group will communicate with their LIS retirees the premium impact of remaining in the employer plan versus enrolling as an individual in another Part D plan.
- 3. The Group agrees that the LIS premium subsidy that CMS is paying on behalf of the LIS eligible retiree will be passed through to that retiree.
- 4. The Group will satisfy the requirements above with respect to the premium contributions collected from The Group's retirees.

The GHC Medicare Advantage MAPD Plan Explanation of Benefits Document follows:

This is Your 2009 Evidence of Coverage (EOC)

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Other enclosures:
Formulary

1. Introduction

Thank you for being a member of our Clear Care[®] Essential Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care and drug coverage through our Plan, a Medicare Advantage Health Maintenance Organization “HMO”; you are still covered by Medicare, but you are getting your health care and/or Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. Our plan’s contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn’t covered.
- How to get the care you need or your prescriptions filled, including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

The geographic service area for our Plan.

The counties and parts of counties in our service area are listed below.

Grays Harbor (Group Health Service Area in Grays Harbor County includes only these zip codes: 98541; 98557; 98559; 98568), Mason (Group Health Service Area in Mason County includes only these zip codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, and 98592), Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom Counties, WA.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage, including the Primary Care Physician you chose and other information. Doctors, hospitals, pharmacists and other network providers use your membership record to know what services or drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Customer Service if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

While you are a member of our Plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items or drugs. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and/or drugs. If your membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. There is a sample card in Section 10 to show you what it looks like.

The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers and pharmacies including those closest to you. If you don't have the Provider Directory, you can get a copy from Customer Service. You may ask Customer Service for more information about our network providers, including their qualifications. Customer Service can give you the most up-to-date information about changes in our network providers and about which ones are accepting new patients. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. A complete list of network providers is also available on our Web site, www.ghc.org/medicare.

You must use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care out-of-area, or for out of the area dialysis services. See the benefits chart in Section 10 for more specific out-of-network coverage information.

The Provider Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a complete Provider Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Provider Directory every year that we don't send you a complete Provider Directory. You can use it to find the network pharmacy closest to you. If you don't have the Provider Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our Web site, www.ghc.org/medicare

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
 - **Annual Deductible**-The amount paid before you start getting prescription coverage.
 - **Amount Paid For Prescriptions**-The amounts paid that count towards your initial coverage limit.
 - **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage**-The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your deductible, coinsurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information)."

As a member of our Plan, you pay:

- 1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is \$96.40 in 2009. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than \$85,000, or if you are married (file a joint tax return) and your yearly income is more than \$170,000.)

If your Yearly Income is*		In 2009, you pay*
File individual tax return	File joint tax return	
\$85,000 or below	\$170,000 or below	\$96.40
\$85,001-\$107,000	\$170,001-\$214,000	\$134.90
\$107,001-\$160,000	\$214,001-\$320,000	\$192.70
\$160,001-\$213,000	\$320,001-\$426,000	\$250.50
Above \$213,000	Above \$426,000	\$308.30

*If you pay a Part B late-enrollment penalty, the premium amount is higher.

- 2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).
- 3) Your monthly premium for our Plan.

Your monthly premium for our Plan is listed in Section 10. (If you signed up for extra benefits, also called "optional supplemental dental benefits", then you pay an additional premium each month for these extra benefits.) If you have any questions about your Plan premiums or the payment programs, please call Customer Service.

As a member of our Plan, you pay a monthly plan premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for all or part of the monthly premium)

Your monthly premium for our plan is listed in Section 10.

If you get benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your monthly plan premium.

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs".

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium.

Option one: Pay your monthly plan premium directly to our Plan.

You may decide to pay your premium directly to our Plan. You will receive a monthly billing statement, which you may pay by check, credit card or debit card. Checks should be mailed to Group Health, P.O. Box 34900, Seattle, WA 98124-1900 by the 1st of each month. A \$20 fee will be charged for NSF checks. If you wish to pay your premium by credit card or debit card call Customer Service at the number referenced in Section 8 and they will assist you.

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account each month. Deductions will be made between the 6th and the 9th of each month. If you are interested in the Automatic Payment Plan (APP), please call Customer Service and ask for an application.

Option two: You may have your monthly plan premium directly deducted from your monthly Social Security payment.

Contact Customer Service for more information on how to pay your monthly plan premium this way.

Note: We don't recommend this option if you are getting extra help for your monthly plan premium payment from another payer. Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process.

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. If our monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll

in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is \$30.36. Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Service to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help.

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by a certain date, which includes a grace period, we will end your membership in our Plan. Our plan's grace period is 60 calendar days from the date of the past due notice. If we end your membership, you will have Original Medicare Plan coverage.

Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan.

If you signed up for extra benefits ("optional supplemental dental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within 60 calendar days, we will end coverage for the extra benefits. If you want to terminate your extra benefits, you must notify us in advance.

What extra help is available to help pay my plan costs?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

- 1. You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare

premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.

- 2. You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than \$15,600 (single with no dependents) or \$21,000 (married and living with your spouse with no dependents), and your resources are less than \$11,990 (single) or \$23,970 (married and living with your spouse). These resource amounts include \$1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs” that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs”.

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. Please send our Membership department any documentation you have so that we may update our member records accordingly. Proof documentation includes any paperwork you received from either CMS or SSA confirming your eligibility for the Low-Income Subsidy (LIS) or any paperwork you have received from the State of Washington’s Department of Social and Health Services (DSHS) confirming your Medicaid eligibility.

When we receive the evidence showing your co-payment level, we will update our system or implement other procedures so that you can pay the correct co-payment when you get your next prescription at the pharmacy. Please be assured that if you overpay your co-payment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn’t collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Important Information

We will send you a Medicare COB Questionnaire so that we can know what other health and/or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health and/or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health and/or prescription drug coverage, please call Customer Service to update your membership records.

2. How You Get Care and Prescription Drugs

How You Get Care

What are “providers”?

“Providers” is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are “network providers”?

“A provider is a “network provider” when they participate in our Plan. When we say that network providers “participate in our Plan,” this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as “plan providers.”

What are “covered services”?

“Covered services” is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for “covered services”?

The amount you pay for covered services is listed in Section 10.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Customer Service or send the bill to us for payment.

Choosing Your Primary Care Physician (PCP)

- What is a PCP?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP’s approval first (this is called getting a “referral” to a specialist).

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan.

- What types of providers may act as a PCP?

You may choose a PCP from any of our available Family Medicine or Internal Medicine physicians.

- How do you choose/change a PCP if member desires or when PCP leaves plan?

To get started using Group Health, the most important thing for you to do first is to choose a Personal Care Physician. You may do this by contacting the Group Health Medicare Customer Service Department at the phone number listed on the front cover of this booklet. Some members choose a PCP close to home; others pick a PCP close to work. There are no special rules to follow. Your PCP should be in a convenient location for you. If there is a particular Group Health specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. You should also ask whether the PCP has a referral relationship with any specialist or hospital you are currently seeing. A list of providers and their telephone numbers are listed in your Provider Directory or you may contact Group Health Medicare Customer Service for details.

You may change your PCP at any time. Simply call Group Health Medicare Customer Service and we will check to make sure the doctor you choose is accepting new patients. Please let us know if you are getting home health agency services or using durable medical equipment so we can help with the transfer of your care or equipment. We will make the change for you and tell you over the phone when this change will go into effect.

Sometimes a PCP, specialist, clinic, hospital or other plan provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. If your PCP leaves our Plan, we will let you know and help you choose another PCP so that you can keep getting covered services.

- What is the role of a PCP?

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without contacting your PCP first.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP must give approval in advance (such as giving you a referral to see certain specialist). In some cases, your PCP will **ALSO** need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. Section 3 tells how we will protect the privacy of your medical records and personal health information.

- What services does the PCP furnish (e.g. routine medical care) and what services can members get on their own?

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- your x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care

You may get the following services on your own without approval in advance:

- Routine women’s health care, which include breast exams, mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider

- Flu shots AND PNEUMONIA VACCINATIONS as long as you get them from a network provider.
 - Chiropractic services (as long as you get them from a plan provider.)
 - Emergency services, whether you get these services from network providers or out-of-network providers
 - Urgently needed care that you get from out-of-network providers when you are temporarily outside the Plan's service area or when you are in the service area but, because of unusual or extraordinary circumstances, the Network providers are temporarily unavailable or inaccessible.
 - Dialysis (kidney) services that you get at a Medicare certified dialysis facility when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.
- What is the role of the PCP in coordinating covered services?

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 3 tells you how we will protect the privacy of your medical records and personal health information.

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists that require referrals to visit include but are not limited to such doctors as:

- Physical therapists,
- Occupational therapists,
- Radiologists.

It is very important to get a referral (approval in advance) from your PCP before you see certain specialists or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

- For what services will the PCP need to get prior authorization from the plan?

Services that require prior authorization are set forth in Section 10.

- Explain if the selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers, i.e. sub-network, referral circles.

Your PCP can refer you to any specialist or hospital within our network.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. Customer Service can assist you in finding and selecting another provider.

Getting care if you have a medical emergency or an urgent need for care

What is a “medical emergency”?

A “medical emergency” is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don’t need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your membership card.

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States. **WE DISCUSS** filling prescriptions when you cannot access a network pharmacy later in this section.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information.)
- For Emergencies or ambulance services outside of the country, see Section 10 for more information.

What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in “What is a ‘medical emergency’” above. If you get any extra care after the doctor says it wasn’t a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a network provider.** We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of “urgently needed care” that is given below.

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Anywhere Worldwide.
- Temporarily absent from the Plan’s authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition, and
- It isn’t reasonable given the situation for you to obtain medical care through the Plan’s participating provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a “medical emergency” and “urgently needed care”?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A “medical emergency” occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. “Urgently needed care” is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan’s service area, you require urgently needed care, then you may get this care from any provider.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Group Health Claims Department, P.O. Box 34585, Seattle, WA 98124-1585, so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Customer Service.

What is your cost for services that aren’t covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare’s coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren’t covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren’t medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn’t medically necessary based on Medicare’s coverage rules, you may have to pay all of the costs of the service if you didn’t ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Customer Service and tell us you would like a decision on whether the service will be covered before you get the service.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs will not count toward your out-of-pocket maximum. You can call Members Services when you want to know how much of your benefit limit you have already used.

How can you participate in a clinical trial?

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. Inpatient hospital services are unlimited as long as the criteria for this benefit has been met.

How you get prescription drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 10.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under “Utilization Management.”

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our www.ghc.org/medicare. You may also call Customer Service to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or co-payment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug’s tier placement. See Section 5 to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations or quantity limits on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, or add quantity limits or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug’s safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn’t on the formulary?

If your prescription isn’t listed on your copy of our formulary, you should first check the formulary on our www.ghc.org/medicare which we update at least monthly (if there is a change). In addition, you may contact

Customer Service to be sure it isn't covered. If Customer Service confirms that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary on our www.ghc.org/medicare.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 5 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Section 10 for information about non-Part D drugs.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our www.ghc.org/medicare for more information about these requirements and limits.

- The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 9 doses per defined prescription period (i.e., per 30-day period) for IMITREX tablets.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our www.ghc.org/medicare, or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 5 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a network pharmacy, there may be a difference in your cost-sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. You should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Provider Directory. You can also visit our www.ghc.org/medicare or call Customer Service.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Provider Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call Customer Service to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail-order-pharmacy service?

You can use our network mail-order service to fill 30 day prescriptions for all drugs.

When you order prescription drugs on the maintenance list, you may order up to a 90-day supply of the drug. The maintenance list consists of drugs you take on a regular basis, for a chronic or long term medical condition. The formulary list tells you which drugs are on the maintenance list.

Generally, it takes the mail-order pharmacy 10 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. If your mail order is delayed beyond 7 business days you may pick up your prescription at any Group Health network pharmacy.

You are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Instead, you have the option of using another network retail pharmacy or a pharmacy in our network to obtain a supply of maintenance medications. Some of these retail pharmacies agree to accept the mail-order cost-sharing amount for an extended supply of maintenance medications, which may result in no out-of-pocket payment difference to you. Your Provider Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of maintenance medications. You can also call Customer Service for more information.

To get order forms and information about filling your prescriptions by mail, you may ask your doctor to fax the prescription directly to the Group Health Mail Order Pharmacy at 206-901-4443 or 1-800-350-1683, or phone it in to 206-901-4444 or 1-800-245-7979. You may also access the mail-order pharmacy service online through your My Group Health account. A new prescription may also be mailed to Group Health Mail Order Pharmacy, PO Box 34383, Seattle, WA 98124-1383. You may obtain mail order re-fill forms by calling the Group Health Mail Order Pharmacy at 1-800-245-7979. Please note that you must use our network mail-order service. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just coinsurance OR co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

- We will cover prescriptions that are filled at an out-of-network pharmacy for prescriptions related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.
- If you are traveling within the US, but outside of the Plan's service area, and you become ill, or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.
- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.

- If you are trying to fill a covered prescription drug that is not regularly stocked at a network pharmacy or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may obtain your medications while you are outside of the service area through our mail-order pharmacy. You may call Customer Service for assistance or order on-line at www.ghc.org.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above (“How do you fill prescriptions outside the network?”), the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs paid for in full when you don’t have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you don’t have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs purchased at a better cash price.** In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan’s benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan’s benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. **Please include your receipt(s) with your written request.**

Please send your written reimbursement request to **Group Health Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585**. Please submit your reimbursement requests no later than March 31st, 2010.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, our Plan’s medical (Part C) benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, our plan’s Part D benefit will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they aren’t covered by our medical

benefit (Part C)). We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs aren't otherwise covered by our plan's medical benefit (Part C)). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage Plan, Prescription Drug Plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Provider Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Customer Service.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through our Plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). Please refer to your Provider Directory to find an I/T/U pharmacy in your area. For more information, contact Customer Service.

Home infusion pharmacies

Please refer to your Provider Directory to find a home infusion pharmacy provider in your area. For more information, contact Customer Service.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and aren't already covered by our Plan's medical benefit (Part C). This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service.

Your right to see plan providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from plan providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in [Section 5](#).

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with SHIBA at the Washington State Office of the Insurance Commissioner by writing to SHIBA HelpLine, Office of the Insurance Commissioner, P.O. Box 40256, Olympia, WA 98504-0256, or calling the toll-free SHIBA Helpline at 1-800-562-6900.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Customer Service.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies and/or providers

You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Customer Service.

Your right to get information about your prescription drugs, Part C medical care or services, and costs

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. See [Section 5](#) for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as prior authorization, which may apply to your plan. Please review our formulary www.ghc.org/medicare or call Customer Service for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See [Section 4](#) and [Section 5](#) for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Customer Service at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in [Section 8](#) of this booklet.
3. Visit www.medicare.gov to view or download the publication “Your Medicare Rights & Protections.”
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called “coordination of benefits” because it involves coordinating all of the health or drug benefits that are available to you.
- You are required to tell our Plan if you have additional health insurance or drug coverage. Call Customer Service.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren’t covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service.

4. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in [Section 5](#) of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs, Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the Part C medical care or services or Part D drugs you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in [Section 5](#).

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Customer Service.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a “fast” decision or a “fast” appeal. We discuss these fast decisions and appeals in [Section 5](#).
- We don’t give you a decision within the required time frame.
- We don’t give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don’t forward your case to the Independent Review Entity if we do not give you a decision on time.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor’s offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called “filing a grievance.”

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your “representative.” You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) or **Part D Grievances** (for complaints about Part D drugs) in [Section 8](#). We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this [Group Health’s grievance procedure](#).** For this process your grievance requests must be in writing, and mailed

to Group Health Medicare Customer Service Medicare Grievance, P.O. Box 34590, Seattle WA 98124-1590 or fax: 206-901-4612, or From www.ghc.org click “Contact Us” or you may call the number in Section 8 of this booklet to contact Group Health Customer Service. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a “fast grievance,” meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in [Section 5](#).

For quality of care problems, you may also complain to Qualis Health

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with Qualis Health, we must help Qualis Health resolve the complaint. See [Section 8](#) for more information about Qualis Health and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part D Prescription Drug(s) and/or Part C Medical Care and Service(s)

Introduction

This section explains how you ask for coverage of your Part D drug(s) and Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs and/or Part C medical care or services. For more information about grievances, see [Section 4](#).

Part 1. Requests for Part D drugs and Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for Part D drugs and/or medical care or services or payment

This part explains what you can do if you have problems getting the Part D drugs and/or Part C medical care or service you request, or payment (including the amount you paid) for a Part D drug and/or Part C medical care or service you already received.

If you have problems getting the Part D drugs and/or Part C medical care or services you need, or payment for a Part D drug and/or Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug and/or Part C medical care or service you need, or paying for a Part D drug and/or Part C medical care or service you already received. Initial decisions about Part D drugs are called "**coverage determinations**." Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part D drug and/or Part C medical care or service you are requesting, or pay for the Part D drug and/or Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits requirements. Requesting an exception to a

utilization management tool is a type of formulary exception. **See "What is an exception?" below for more information about the exceptions process.**

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances.
- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See [Section 2](#) ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our non-preferred tier subject to the tiering exceptions process tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred generic tier subject to the tiering exceptions process tier instead. This would lower the coinsurance amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary or the Part D drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under Part D Coverage Determinations in [Section 8](#) to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your “appointed representative.” You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under **"Part C Organization Determinations"** in [Section 8](#). If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under **"Part D Coverage Determinations"** in [Section 8](#). To learn how to name your appointed representative, you may call Customer Service.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a “standard” or “fast” initial determination

A decision about whether we will give you, or pay for, the Part D drug and/or Part C medical care or service you are requesting can be a “standard” decision that is made within the standard time frame, or it can be a “fast” decision that is made more quickly. A fast decision is also called an “expedited” decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug and/or Part C medical care or service you, your doctor, or your representative fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in [Section 8](#).

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part D drug and/or Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in [Section 8](#).

If you want to request a fast decision after regular weekday business hours, please call us and leave a message when prompted to do so. Group Health Customer Service staff will respond as soon as possible.

Be sure to ask for a “fast,” or “expedited” review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The

letter will also tell you how to file a “fast grievance.” You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see [Section 4](#)). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, dosage limits, quantity limits requirements, we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received.

If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Part C medical care or services you have not yet received.

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. For more information about fast grievances, see [Section 4](#).

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received.

If you receive a “fast” decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see [Section 4](#).

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received.

We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

- For a decision about payment for Part C medical care or services you already received.

Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received.

We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "**redetermination**." An appeal to the plan about Part C

medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug and/or Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about medical care or services) in [Section 8](#).

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug and/or Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in [Section 8](#).

If you want to request a fast decision after regular weekday business hours, please call us in the Appeals Department at 1-866-458-5479 and leave a message when prompted to do so. Group Health Appeals Department staff will respond as soon as possible.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see [Section 4](#)). If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in [Section 8](#).

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in [Section 8](#).

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in [Section 8](#). We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received.

After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received.

After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you

already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

We must cover the Part D drug you requested no later than 72 hours after we receive your request.

- For a decision about payment for Part C medical care or services you already received.

We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received.

We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity. We are allowed to charge you a fee for copying and sending this information to you.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at Appeal Level 1.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.
- For a decision about payment for Part C medical care or services you already received.

We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received.

We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services.

We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug and/or Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section “**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**” below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section “**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**” below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.
- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Customer Service or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI>). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable co-payments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the “Quality Improvement Organization”?

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in; Qualis Health is the QIO for Washington State. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting Qualis Health to review your hospital discharge

You must quickly contact Qualis Health. The Important Message from Medicare gives the name and telephone number of Qualis Health and tells you what you must do.

- You must ask the Qualis Health for a “**fast review**” of your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from Qualis Health no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from Qualis Health.**
- Qualis Health will look at your medical information provided to them by us and the hospital.
- During this process you will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Customer Service or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>.
- Qualis Health will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if *Qualis Health* decides in your favor?

We will continue to cover your hospital stay (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if *Qualis Health* agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after *Qualis Health* gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after *Qualis Health* gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask *Qualis Health* to review its first decision if you make the request within 60 days of receiving *Qualis Health*'s first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after *Qualis Health* gave you its first decision.

What happens if you appeal *Qualis Health* decision?

Qualis Health has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If *Qualis Health* agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If *Qualis Health* upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask *Qualis Health* for a review by the deadline?

If you do not ask *Qualis Health* for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Customer Service or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting *Qualis Health* review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask Qualis Health, the Washington state Quality Improvement Organization (the “QIO”) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for *Qualis Health* review?

You must quickly contact Qualis Health. The written notice you got from your provider gives the name and telephone number of Qualis Health and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact Qualis Health no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during *Qualis Health*’s review?

Qualis Health will ask why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish. Qualis Health will also look at your medical information, talk to your doctor, and review information that we have given to Qualis Health. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Customer Service or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>.

Qualis Health will make a decision within one full day after it receives all the information it needs.

What happens if Qualis Health decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if Qualis Health agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask Qualis Health to review its first decision if you make the request within 60 days of receiving Qualis Health’s first denial of your request.

What happens if you appeal Qualis Health decision?

Qualis Health has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If Qualis Health agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10

If Qualis Health upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask Qualis Health for a review by the deadline?

If you do not ask Qualis Health for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

6. Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the “Annual Election Period”), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- If you are planning on enrolling in a new Medicare Advantage plan: Simply join the new plan. You will be disenrolled from our plan when your new plan’s coverage begins on January 1.
- If you are planning on switching to the Original Medicare Plan and joining a Medicare Prescription drug plan: Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- If you are planning on switching to the Original Medicare Plan without a Medicare Prescription drug plan: Contact Customer Service for information on how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

<p>If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage</p> <p>If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan</p>		
<p>Special Enrollment Periods for limited special exceptions, such as:</p> <ul style="list-style-type: none"> • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home) 	<p>Determined by exception.</p>	<p>Generally, first day of next month after plan receives your enrollment request</p>

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the “*Medicare & You*” handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under “Search Tools,” select “Find a Medicare Publication.”

Until your membership ends, you must keep getting your Medicare services and/or prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care and/or prescription drugs as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Customer Service for more information and to help us coordinate with your new plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan’s network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy including our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B. **PART B -ONLY GRANDFATHERED MEMBERS NEED TO STAY CONTINUOUSLY ENROLLED IN MEDICARE PART B.**
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership (“disenroll” you)”. If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan’s service area. [Section 10](#) gives more information about getting care when you are away from the service area. If you have been a member of our plan continuously since before January 1999, when you lived outside our service area, you may continue your membership. However, if you move and your move is still outside our service area, you will be disenrolled from our Plan, as stated above.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60-day grace period during which you may pay the Plan premiums before your membership ends.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug/item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs/services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs/services are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific drugs/services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug/service.

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial care -- Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing,

bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Customer Service.

Deductible -- The amount you must pay for the drugs you receive before our Plan begins to pay its share of your covered drugs.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Durable medical equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us or one of our network providers/pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care -- Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care -- A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit

www.medicare.gov and under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048).

Inpatient Care – Health care that you get when you are admitted to a hospital.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible and before your total drug expenses, have reached \$2,700, including amounts you’ve paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan– Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our Plan, or “plan member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Plan provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays

network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Optional supplemental dental benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental dental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Dental Benefits in order to get them.

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-network pharmacy – A pharmacy that doesn’t have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see “**Medicare Advantage (MA) Plan**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network services are covered only if your doctor or other network provider gets “prior authorization” from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state, Qualis Health, and Section 5 for information about making complaints to Qualis Health.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service area – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled nursing facility (SNF) care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 2 explains about “urgently needed” services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Customer Service

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you.

- CALL** **1-888-901-4600** Calls to this number are free.
Monday through Friday, 8 a.m. to 8 p.m.
November 15 through February 28 we offer extended hours from 8 a.m. to 8 p.m. seven days a week
- TTY/TDD** **771- or 1-800-833-6388** Calls to this number are free.
- FAX** **206-901-6205**
- WRITE** Group Health Medicare Customer Service Department, P.O. Box 34590, Seattle, WA 98124-1589
- EMAIL** www.ghc.org – “Contact Us”
- VISIT** 12401 East Marginal Way South, Tukwila, WA 98168
- WEBSITE** www.ghc.org

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations (about your Medicare Care and Services)

- CALL** **1-888-901-4600**. Calls to this number are free.
- TTY/TDD** **711 or 1-800-833-6388**. This number requires special telephone equipment. Calls to this number are free.
- FAX** **206-901-6205**
- WRITE** Group Health Medicare Customer Service Department, P.O. Box 34590, Seattle, WA 98124-1589

For information about Part C organization determinations, see Section 5.

Part C & D Grievances (about your Medical Care/Services and Part D Prescription Drugs)

- CALL** **1-888-901-4600**. Calls to this number are free.
- TTY/TDD** **711 or 1-800-833-6388**. This number requires special telephone equipment. Calls to this number are free.
- FAX** **206-901-6205**
- WRITE** Group Health Medicare Customer Service Department, P.O. Box 34590, Seattle, WA 98124-1589

For information about Part C & D grievances, see Section 4.

Part C & D Appeals (about your Medical Care/Services and Part D Prescription Drugs)

CALL 1-866-458-5479. Calls to this number are free.

TTY 800-833-6388. This number requires special telephone equipment. Calls to this number are free.

FAX 206-901-7340

WRITE Group Health, Medicare Appeals Coordinator, P.O. Box 34593, Seattle, WA 98124-1593

VISIT 12400 EAST MARGINAL WAY SOUTH, TUKWILA, WA 98168

For information about Part C & D appeals, see Section 5.

Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL 1-888-901-4600. Calls to this number are free.

TTY/TDD 711 or 1-800-833-6388. This number requires special telephone equipment. Calls to this number are free.

FAX 206-901-6205

WRITE Group Health Medicare Customer Service Department, P.O. Box 34590, Seattle, WA 98124-1589

For information about Part D coverage determinations, see Section 5.

Part D Reimbursement Requests (about your Part D prescription drugs)

CALL 1-888-901-4600. Calls to this number are free.

TTY/TDD 711 or 1-800-833-6388. This number requires special telephone equipment. Calls to this number are free.

FAX 206-901-6205

WRITE Group Health Medicare Claims Department, P.O. Box 34585, Seattle, WA 98124-1585

Part D Grievances (about your Part D Prescription Drugs)

CALL 1-888-901-4600. Calls to this number are free.

TTY/TDD 711 or 1-800-833-6388. This number requires special telephone equipment. Calls to this number are free.

FAX 206-901-6205

WRITE Group Health Medicare Customer Service Department, P.O. Box 34590, Seattle, WA 98124-1589

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D Prescription Drugs)

CALL 1-866-458-5479. Calls to this number are free.

TTY	800-833-6388. This number requires special telephone equipment. Calls to this number are free.
FAX	206-901-7340
WRITE	Group Health, Medicare Appeals Coordinator, P.O. Box 34593, Seattle, WA 98124-1593
VISIT	12400 EAST MARGINAL WAY SOUTH, TUKWILA, WA 98168

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose “Find Helpful Phone Numbers and Resources,” or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

SHIBA

SHIBA is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. SHIBA can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHIBA has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact SHIBA by writing SHIBA HelpLine, Office of Insurance Commissioner, P.O. Box 40256, Olympia, WA 98504-0256. SHIBA can be reached by calling, 1-800-562-6900. You can also find the website for SHIBA at www.insurance.wa.gov on the Web. Select “SHIBA Helpline” on the Washington State Office of the Insurance Commissioner website.

Qualis Health/Quality Improvement Organization

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in; Qualis Health is the QIO for Washington state. The doctors and other health experts in Qualis Health review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact Qualis Health, the QIO in Washington State, at PO BOX 33400, Seattle, WA 98133-0400 or 10700 Meridian Ave. N., Suite 100, Seattle, WA 98133-9075; telephone number (206) 364-9700 or Fax: (206) 368-2419.

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and nursing

homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful Phone Numbers and Websites.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact the Washington State Department of Social and Health Services (DSHS) Medical Assistance Administration at 1-800-562-3022, or write to the Customer Service Center, P.O. Box 45505, Olympia, WA 98504-5505.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors’ benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or “Group”) Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse’s current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse’s) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If Group Health provides benefits under this Agreement for the treatment of the injury or illness, Group Health will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness. This section more fully describes Group Health's subrogation and reimbursement rights.

"Injured Person" under this section means a Member covered by the Agreement who sustains an injury and any spouse, dependent or other person or entity that may recover on behalf of such Member, including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "Group Health's Medical Expenses" means the expenses incurred and the reasonable value of the benefits provided by Group Health for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, Group Health shall have the right to recover Group Health's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." Group Health shall be subrogated to and may enforce all rights of the Injured Person to the extent of Group Health's Medical Expenses.

Group Health's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages. However, in the case of Medicare Advantage Members, Group Health's right of subrogation shall be the full amount of Group Health's Medical Expenses and is limited only as required by Medicare.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorist funds, then Group Health's Medical Expenses provided or to be provided to the Injured Person are secondary, not primary. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of Group Health services is constructive notice of this provision in its entirety and agrees to reimburse Group Health for the benefits the Injured Person received as a result of the events causing the injury.

The Injured Person and his/her agents shall cooperate fully with Group Health in its efforts to collect Group Health's Medical Expenses. This cooperation includes, but is not limited to, supplying Group Health with information about

any third parties, defendants and/or insurers related to the Injured Person's claim and informing Group Health of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit Group Health, at Group Health's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow Group Health to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for Group Health's Medical Expenses.

The Injured Person and his/her agents shall do nothing to prejudice Group Health's subrogation and reimbursement rights. The Injured Person shall promptly notify Group Health of any tentative settlement with a third party and shall not settle a claim without protecting Group Health's interest. If the Injured Person fails to cooperate fully with Group Health in recovery of Group Health's Medical Expenses, the Injured Person shall be responsible for directly reimbursing Group Health for Group Health's Medical Expenses and Group Health retains the right to bill the Injured Person directly for Group Health's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in their possession until Group Health's subrogation and reimbursement rights are fully determined.

Group Health shall not pay any attorneys' fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by Group Health prior to any collection efforts. When reasonable collection costs have been incurred with Group Health's prior written agreement to recover Group Health's Medical Expenses, there shall be an equitable apportionment of such collection costs between Group Health and the Injured Person subject to a maximum responsibility of Group Health equal to one-third of the amount recovered on behalf of Group Health. Under no circumstance will Group Health pay legal fees for services which were not reasonably and necessarily incurred to secure recovery, which do not benefit Group Health or where no written fee agreement has been entered into with Group Health.

To the extent the provisions of this Subrogation and Reimbursement section are deemed governed by ERISA, implementation of this section shall be deemed a part of claims administration under the Agreement and Group Health shall therefore have sole discretion to interpret its terms.

10. How Much You Pay for Your Part C Medical Benefits and/or Part D Prescription Drugs

Your Monthly Premium for Our Plan

Your monthly premium for our Plan is \$168.

If you signed up for extra benefits, also called “optional supplemental dental benefits”, then you pay an additional premium each month for these extra benefits. If you have any questions about your Plan premiums or the payment programs, please call Customer Service.

If you get your benefits from your current or former employer, or from your spouse’s current or former employer, call the employer’s benefits administrator for information about your Plan premium.

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your “Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs.” You can also get that information by calling Customer Service.

You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under “General Exclusions” you can find information about services that are not covered and limitations on certain services. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section.

What do you pay for covered services?

Deductibles, co-payments, and coinsurance are the amounts you pay for covered services.

- The “**deductible**” is the amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services.
- A “**co-payment**” is a payment you make for your share of the cost of certain covered services you get. A co-payment is a set amount per service. You pay it when you get the service.
- “**Coinsurance**” is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service.

What is the maximum amount you will pay for covered medical services?

There is a limit to how much you have to pay out-of-pocket for covered health care services each year. Once the total costs for your services, including your co-payments, and coinsurance, reaches \$2,500 then you won’t have to continue paying for these expenses for the remainder of the year. Cost shares for the following services apply to the out-of-pocket maximum: Inpatient Hospital Care, Inpatient Mental Health Care, Doctor Office Visits, Chiropractic Services, Podiatry Services, Outpatient Mental Health Care, Outpatient Services/Surgery, Ambulance Services, Emergency Care, Urgently Needed Care, Outpatient Rehabilitation Services, Durable Medical Equipment, Prosthetic Devices, Diabetes Self-Monitoring Training and Supplies, Diagnostic Tests, X-Rays, and Lab Services, Bone Mass Measurement, Colorectal Screening Exam, Mammograms (Annual Screenings), Pap Smears and Pelvic

Exams, Prostate Cancer Screening Exams, Hearing Services, Vision Services, Physical Exams, Transportation, Other Health Care Professional and Cardiovascular Screening Blood Tests.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets “prior authorization” (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in italics.

See Section 2 for information on requirements for using network providers.

Inpatient Services

Inpatient hospital care

For a Medicare-covered stay at a network hospital or a hospital authorized by Group Health. You are covered up to 365 days per year.

Covered services include:

- Semi-private room (or a private room if medically necessary)
 - Meals including special diets
 - Regular nursing services
 - Costs of special care units (such as intensive or coronary care units)
 - Drugs and medications
 - Lab tests
 - X-rays and other radiology services
 - Necessary surgical and medical supplies
 - Use of appliances, such as wheelchairs
 - Operating and recovery room costs
 - Physical, occupational, and speech language therapy
 - Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.
 - Blood - including storage and administration. Coverage begins with the first pint used.
 - Physician Services
- **You pay:**
 - \$200 each day for day(s) 1-5
 - \$0 each day for day(s) 6-90
 - There is no copayment for additional days received at a network hospital.
 - You are covered for unlimited days each benefit period.
 - *Except in an emergency, your provider must obtain authorization from Group Health.*
 - If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, and Group Health requests that you transfer to a network hospital and you refuse to transfer to a network hospital, you will be responsible for 100% of any subsequent patient care.
-

Benefits chart – your covered services

What you must pay when you get these covered services

Inpatient mental health care

Covered services include mental health care services that require a hospital stay.

- For a Medicare-covered stay at a network hospital, you are covered up to 365 days per year.
- Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. The 190 day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

- You pay:
 - \$200 each day for day(s) 1-5
 - \$0 each day for day(s) 6-90for a Medicare-covered stay at a network hospital. You are covered up to 365 days per year.
- Except in an emergency, your provider must obtain authorization from Group Health.

Skilled nursing facility (SNF) care

You are covered for 100 days for each benefit period. Covered services include:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
- Blood - including storage and administration. Coverage begins with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services

- There is no copayment for services in a Skilled Nursing Facility.
- When a 3 day Medicare covered hospital stay does not occur and the plan determines that the member otherwise meets all Medicare criteria for an acute inpatient hospital stay at the time of admission to a Medicare Certified Skilled Nursing Facility, the plan may authorize Medicare covered Skilled Nursing Facility Care up to the Medicare skilled Nursing Facility day limit per benefit period.
- All Medicare criteria must be met and the stay must be authorized in advance by the plan.

Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered

Covered services include:

When all other Medicare and Group Health criteria have been met, benefits will be covered subject to the following copayments and coinsurances:

- Physician services – covered in full.
- Tests – covered in full.

Benefits chart – your covered services

What you must pay when you get these covered services

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy
- X-ray and isotope therapy – Covered in full
- Radium therapy - \$15 copayment
- Surgical dressings, splints, casts and other devices – 20% coinsurance
- Prosthetic devices – 20% coinsurance
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs and replacements required because of breakage, wear, loss, or a change in the patient's physical condition – 20% coinsurance
- Physical therapy, speech therapy, and occupational therapy, and speech therapy - \$15 copayment per office visit

Home health agency care

Covered services include:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical social services
- Medical equipment and supplies
- There is no copayment for Medicare-covered home health visits.
- *Prior authorization required.*

Hospice care

You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan
- Home care

Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

\$15 copayment for each Medicare-covered Consultation

Outpatient Services

Benefits chart – your covered services

What you must pay when you get these covered services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center
- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.
- Telehealth office visits including consultation, diagnosis and treatment by a specialist
- Second opinion by another plan provider prior to surgery
- Outpatient hospital services
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)

- You pay:
 - \$15 for each primary care doctor office visit for Medicare-covered services.
 - \$15 copayment for each Medicare-covered Consultation and certain Specialist visits.
 - \$200 copayment for services provided in a Medicare-covered ambulatory surgical center and Medicare-covered Outpatient hospital services visit.
- *Prior authorization required for ambulatory surgical center and outpatient hospital service visits.*
- *Prior authorization not required for self-referral visits to certain Group Health specialists at Group Health-operated medical centers only. See Section 2 for more information.*

Chiropractic services

Covered services include:

- Manual manipulation of the spine to correct subluxation

- You pay \$15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
- You pay 100% for routine chiropractic services.
- *Must use plan providers. No referral necessary for plan providers.*

Podiatry services

Covered services include:

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs.

- You pay \$15 for each Medicare-covered visit (medically necessary foot care).
- You pay 100% for routine podiatry care.
- *Prior authorization required.*

Benefits chart – your covered services

What you must pay when you get these covered services

Outpatient mental health care (including Partial Hospitalization Services)

Covered services include:

- Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

- For Medicare-covered Mental Health services, you pay \$15 for each individual/group therapy visit.
- Self-referral to Group Health specialists only at Group Health-operated medical centers only.
- *Prior authorization required for any services received at non-Group Health-operated medical centers.*

Outpatient substance abuse services

- There is no copayment for each Medicare-covered visit.
- *Prior authorization required.*

Outpatient surgery (including services provided at ambulatory surgical centers)

- You pay \$200 for each Medicare-covered visit to an ambulatory surgical center.
- You pay \$200 for each Medicare-covered visit to an outpatient hospital facility.
- *Prior authorization required.*

Ambulance services

Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.

A \$150 co-payment per each one-way trip applies except hospital to hospital ambulance transfers initiated by Group Health which are covered in full.

Benefits chart – your covered services

What you must pay when you get these covered services

Emergency care

Worldwide coverage

- You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 1 day for the same condition.

If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, you must have your inpatient care at the non-plan hospital authorized by the plan and your cost is the cost-sharing you would pay at a plan hospital. However, if you refuse reasonable, medically appropriate transfer to a plan-contracting inpatient facility, your cost-sharing might be higher.

Urgently needed care

Worldwide coverage

- You pay \$15 for each Medicare-covered urgently needed care visit.

Outpatient rehabilitation services

Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy

- You pay \$15 for each Occupational Therapy, Physical Therapy and/or Speech/Language Therapy visit.
- *This is an unlimited benefit.*
- Prior authorization required

Durable medical equipment and related supplies

Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 7.)

- You pay 20% of the cost for each Medicare-covered item.
- *Prior authorization required.*

Prosthetic devices and related supplies – (other

than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.

- You pay 20% of the cost for each Medicare-covered item.
- *Prior authorization required.*

Benefits chart – your covered services

What you must pay when you get these covered services

Diabetes self-monitoring, training and

supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include:

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
- One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts
- Self-management training is covered under certain conditions
- For persons at risk of diabetes: Fasting plasma glucose tests at a frequency determined by you and your physician. You may call the number in Section 8 of this booklet to contact Group Health Customer Service for information on how often we will cover these tests.

- There is no copayment for Diabetes self-monitoring training.
- You pay 20% of the cost for each Medicare-covered Diabetes supply item.
- A \$15 copayment applies for each separate office visit.
- Prior *authorization required*.

Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.

- A \$15 copayment applies for each separate office visit.
- *Prior authorization required*.

Outpatient diagnostic tests and therapeutic services and supplies

Covered services include:

- X-rays
- Radiation therapy
- Surgical supplies, such as dressings
- Supplies, such as splints and casts
- Laboratory tests
- Blood - Coverage of storage and administration begins with the first pint of blood that you need.
- Other outpatient diagnostic tests

- There is no copayment for the following Medicare-covered service(s):
 - Clinical/diagnostic lab services
 - Radiation therapy
 - X-ray visits
- A \$15 copayment applies for each separate physician's office visit.
- *Prior authorization required*.

Benefits chart – your covered services

What you must pay when you get these covered services

Vision care

Covered services include:

- Outpatient physician services for eye care.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.
- Routine eye exam once every 24 months.

- There is no copayment for the following items:
 - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) if obtained from a Medicare-certified facility.
- **You pay:**
 - \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
 - \$15 for each Group Health-covered routine eye exam, limited to 1 exam once every 24-months.

Preventive Care and Screening Tests

Bone-mass measurements

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

- There is no copayment for Medicare-covered Bone Mass Measurement.
- A \$15 copayment applies for each separate office visit.
- *Prior authorization required*

Colorectal screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months
- Fecal occult blood test, every 12 months

For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy

- There is no copayment for Medicare-covered Colorectal Screening Exams.
- A \$15 copayment applies for each separate office visit.
- A \$200 copayment applies for services provided at either a Medicare-covered ambulatory surgical center visit or Medicare-covered Outpatient hospital services visit.
- *Prior authorization required.*

Benefits chart – your covered services

What you must pay when you get these covered services

Immunizations

Covered services include:

- Pneumonia vaccine
- Flu shots, once a year in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk

We also cover some vaccines under our outpatient prescription drug benefit.

- There is no copayment for Pneumonia and Flu vaccines. (No referral necessary).
- There is no copayment for the Hepatitis B vaccine. Referral required.
- *Referral required for other immunizations. Please contact the Group Health Medicare Customer Service Department for more information.*

Mammography screening

Covered services include:

- One baseline exam between the ages of 35 and 39
- One screening every 12 months for women age 40 and older

- There is no copayment for Medicare-covered Screening Mammograms.
- *No referral necessary for Medicare-covered screenings.*
- A \$15 copayment applies for each separate office visit.

Pap tests, pelvic exams, and clinical breast exam

Covered services include:

- For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months
- If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months

- *There is no copayment for Medicare-covered Pap Smears.*
- A \$15 copayment applies for each separate office visit for Pelvic Exams.

Prostate cancer screening exams

For men age 50 and older, covered services include the following - once every 12 months:

- Digital rectal exam
- Prostate Specific Antigen (PSA) test

- There is no copayment for Medicare-covered Prostate Cancer Screening Exam.
- A \$15 copayment applies for each separate office visit.
- *Prior authorization required.*

Cardiovascular disease testing

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). You may call the number in Section 8 of this booklet to contact Group Health Medicare Customer Service for information on how often we will cover these tests.

- There is no copayment for Medicare-covered Cardiovascular screening blood tests.
- A \$15 copayment applies for each separate office visit.
- *Prior authorization required*

Benefits chart – your covered services

What you must pay when you get these covered services

Physical exams

Routine physical exams

- There is no copayment for routine physical exams.
- You are covered up to 1 exam(s) every two years.
- *Must use plan providers, no referral necessary for plan providers*

Other Services

Dialysis (Kidney)

Covered services include:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2)
 - Inpatient dialysis treatments (if you are admitted to a hospital for special care)
 - Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
 - Home dialysis equipment and supplies
 - Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)
- You are covered in full for each Medicare-covered visit.
 - *Prior authorization required except renal dialysis services out of our Plan's service area.*

Medicare Part B Prescription Drugs

These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan.

There is no benefit limit on drugs covered under original Medicare.

Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Benefits chart – your covered services

What you must pay when you get these covered services

Section 2 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.

Additional Benefits

Dental Services

Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

- In general, you pay 100% for dental services.
- See pages 88-92 for additional information about the Optional Dental Benefit. An additional premium applies for the Optional Dental Benefit.

Hearing Services

- Diagnostic hearing exams.
- Routine hearing test

- You pay:
 - \$15 for each diagnostic hearing exams (every 24 months).
 - \$15 for each routine hearing test up to 1 test once every 24-months.

Vision care

Routine eye exam once every 24 months.

\$15 for each Group Health-covered routine eye exam, limited to 1 exam once every 24-months.

Benefits chart – your covered services

What you must pay when you get these covered services

Health and wellness education programs

- **Health Club Membership**

You are covered in full for the SilverSneakers Program Health Club Membership.

The SilverSneakers fitness program is part of your Group Health Medicare coverage. It's a fitness program designed with you in mind, and comes with a health club membership so you can keep yourself staying fit.

For more information, call the Group Health Resource Line toll-free at 1-800-992-2279 or 206-326-2800, or the TTY line at 711 or 1-800-833-6388.

- **EnhanceFitness**

EnhanceFitness

Group Health Medicare members can participate at no additional cost in the Lifetime Fitness program. The classes meet three days a week. The hour-long classes are a well-rounded combination of stretching, low-impact aerobics or walking, strength training, and balance taught by professional instructors.

Call the Group Health Resource Line toll-free at 1-800-992-2279, 206-326-2800 or Senior Services at 206-727-6259, or the TTY line at 711 or 1-800-833-6388 to find the participating Lifetime Fitness program facility nearest you.

Must use plan providers.

Benefits chart – your covered services

What you must pay when you get these covered services

- **Smoking & Tobacco Use Cessation (Group Health Covered)**

Group Health Covered:

When member is enrolled and actively participating in the Free and Clear Program[®], services provided through Group Health related to smoking and tobacco use cessation are covered, limited to: Participation in individual or group programs; plan approved nicotine replacement therapy (nicotine patches, nicotine gum, and nicotine lozenges) when obtained through the Group Health Mail Order Pharmacy; Educational materials covered in full

Prescription Bupropion and Chantix covered at applicable cost shares for members enrolled in a Clear Care[®] plan with Part D; Free & Clear Program[®] enrollment is not required to use this prescription drug benefit.

- **Smoking & Tobacco Use Cessation (Medicare Covered)**

Medicare Covered:

Medicare will pay for two cessation-counseling attempts per year; each attempt includes 4 sessions each of either shorter visits of 3 to 10 minutes each, or longer visits (longer than 10 minutes each) depending on what the member and their doctor decide. *Must use plan providers.*

Transportation (routine)

- A \$150 co-payment per each one-way trip applies. Limited to ambulance services only when medically necessary and authorized in advance by Group Health.
- *All Group Health criteria must be met.*

Home Infusion Therapy Services

Covered in full.

Chemotherapy – Chemotherapy is covered when ordered by a Group Health provider and all Group Health referral protocol has been met. When providing care and services to Medicare patients, Group Health MUST use Medicare-certified providers and facilities.

- A \$15 copayment applies for each separate office visit.
- *Prior authorization required.*

Benefits chart – your covered services

What you must pay when you get these covered services

Out of Area Travel

Non-emergent and/or non-urgently needed care received while temporarily traveling outside Group Health's Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per member per calendar year. Our Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Enrollee is responsible for all Medicare inpatient and outpatient deductibles and coinsurances

Extra “optional supplemental” dental benefits you can buy

Our Plan offers some extra benefits that are not covered by the Original Medicare Plan and not included in your benefits package as a Plan member. These extra benefits are called “**Optional Supplemental Dental Benefits**”. If you want these optional supplemental dental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental dental benefits included in this section are subject to the same appeals process as any other benefits.

Optional Supplemental Dental Benefit	
<i>Premium and Other Important Information</i>	You pay \$34 each month, for Optional Supplemental Dental Benefit in addition to your monthly plan premium of \$168 and the Medicare Part B premium.
Dental Services	<ul style="list-style-type: none"> • There is no copayment for the following: <ul style="list-style-type: none"> - Oral exams up to 2 visit(s) every year. - Cleanings up to 2 visit(s) every year. - Dental x-rays up to 1 visit every three years. • You are covered up to a \$1000 maximum for Combined Preventive and/or Comprehensive benefit for ALL dental services each calendar year. • A \$25 annual deductible applies to dental services, except for preventive dental care.

Dental Benefit: The following are Covered Dental Benefits under this Contract and Washington Dental Service (WDS) provides these benefits. These benefits are subject to the limitations and exclusions contained in this Contract. Such benefits (as defined) are available only when rendered by a licensed Dentist or other Washington Dental Service approved Licensed Professional when appropriate and necessary as determined by the standards of generally accepted dental practice and Washington Dental Service. You may contact WDS at their toll-free customer service line, 1-800-554-1907, or TTY: 711, or 1-800-833-6388 (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking) to reach Group Health Customer service for dental inquiries.

A \$25 annual deductible applies to dental services, except for preventive dental care. In addition your dental coverage includes a benefit for periodontal cleaning to be paid at the regular cleaning rate.

Class I

Diagnostic

Covered Dental Benefits: Routine examinations, X-rays, emergency examination and examination by a Specialist in an American Dental Association recognized specialty, carries susceptibility tests.

Limitations: Examinations are covered twice in a calendar year. Complete series (four bitewing x-rays and up to ten periapical x-rays) or panorex x-rays are covered once in a three (3)-year period. Supplementary bitewing x-rays are covered twice in a calendar year.

Exclusions: Diagnostic services and x-rays related to temporomandibular joints (jaw joints), consultations or elective second opinions, study models.

Preventive

Covered Dental Benefits: Prophylaxis (cleaning).

Limitations: Prophylaxis (cleaning) is covered twice in a calendar year.

Exclusions: Plaque control program. Oral hygiene instruction, dietary instruction and home fluoride kits and Cleaning of a prosthetic appliances. (Refer also to General Exclusions).

Class II

Restorative

Covered Dental Benefits: Amalgam, synthetic, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay). Stainless steel crowns. For other restorations such as gold foils, crowns, inlays, or onlays the allowance will be limited to the amount which otherwise would have been allowed for an amalgam restoration.

Limitations: Restorations on the same surface(s) of the same tooth are covered once in a two (2) year period. If a synthetic, composite or filled resin restoration is placed in a posterior tooth, an amalgam allowance will be made for such procedure. The difference in cost is the patient's responsibility. Stainless steel crowns are covered once in a two (2)-year period.

Exclusions: Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion. Overhang removal, re-contouring or polishing of restoration.

Class III

Prosthodontics

Covered Dental Benefits: Denture adjustments and relines.

Limitations: Denture adjustments and relines done more than six (6) months after the initial placement are covered. Subsequent relines will be covered once in a twelve (12) month period.

Exclusions: Dentures, removable partial dentures, fixed bridges and the repair of an existing prosthetic device, duplicate dentures, personalized dentures, cleaning of prosthetic appliances. (Refer also to General Exclusions).

General Exclusions – Dental Benefits

- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, services which are provided to the Eligible Person by any federal or state or provincial government agency or provided without cost to the Eligible Person by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a. Section 1902 of the Social Security Act.
- Root Canals
- Dentistry for cosmetic reasons.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
- Application of desensitizing agents.
- Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental

Association, shall consider if: 1) the services are in general use in the dental community in the State of Washington; 2) the services are under continued scientific testing and research; 3) the services show a demonstrable benefit for a particular dental condition; and 4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause shall be notified of the denial within 20 working days of receipt of a fully documented request.

- Any denial of benefits by Washington Dental Service on the grounds that a given procedure is deemed experimental, may be appealed to Washington Dental Service. By law, Washington Dental Service must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual. Appeals may also be made to Group Health, see Section 5, and Group Health coordinates all appeals with Washington Dental Service
- General anesthesia/intravenous (deep) sedation, except as specified by WDS for certain oral, periodontal or endodontic surgical procedures.
- Analgesics such as nitrous oxide, conscious sedation, or euphoric drugs, injections or prescription drugs.
- In the event an Eligible Person fails to obtain a required examination from a Washington Dental Service appointed consultant Dentist for certain treatments, no benefits shall be provided for such treatment.
- Hospitalization charges and any additional fees charged by the Dentist for hospital treatment.
- Broken appointments.
- Patient management problems.
- Completing insurance forms.
- Habit breaking appliances or orthodontic services or supplies.
- WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
- All other services not specifically included in this Contract as Covered Dental Benefits.

Method of Payment – Dental Benefit

Washington Dental Service shall pay one hundred percent (100%) of the Members Dentist's filed fee for allowable Class I Covered Dental Benefits as they are described.

Washington Dental Service shall pay eighty (80%) of the Member Dentist's filed fee for allowable Class II covered Dental Benefits as they are described.

The amounts payable by Washington Dental Service for Covered Dental Benefits provided by a Dentist who is not a Member Dentist in the State of Washington, shall be the above applicable percentages, applied to the lesser of the Prevailing Fee (the fee which is equivalent to the 51st percentile of fees of member Dentists in the State of Washington as determined by Washington Dental Service based upon confidential fee listings filed with and accepted by Washington Dental Service) or such Dentist's actual charges.

The amounts payable by Washington Dental Services for Covered Dental Benefits provided by a Dentist outside of Washington state shall be the above applicable percentages, applied to the lesser of the Usual, Customary and Reasonable fees (the 90th percentile of the Washington Dental Service approved filed fees for all Member Dentists in the State of Washington) or such Dentist's actual charges.

The maximum amount payable by Washington Dental Service for all classes of Covered Dental Benefits per Eligible Person during each twelve (12) month period January 1 through December 31 shall be one thousand dollars (\$1,000.00). Charges for dental procedures requiring multiple treatment dates shall be considered incurred on the date the service is completed. Amounts paid for such procedures will be applied to the program maximum based on such incurred date.

Getting care using our Plan’s traveler benefit

Non-emergent and/or non-urgently needed care received while temporarily traveling outside Group Health’s Medicare Service Area for up to 6 months at a time is payable at Medicare benefit levels up to \$2,000 per member per calendar year. Our Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services ONLY. Enrollee is responsible for all Medicare inpatient and outpatient deductibles and coinsurances

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won’t pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Customer Service.

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section, and later in this section under “General Exclusions” you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our Web site, www.ghc.org/medicare or contact Customer Service to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., deductible, initial coverage period, the period after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs.” If you do not already qualify for extra help, see “Do you qualify for extra help?” in Section 1 for more information.

Deductible

You will pay a yearly deductible of \$295. After you meet the deductible, you will reach the initial coverage period.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance. Your coinsurance will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

[Drug Tier]	Retail Co-payment/Coinsurance (30 day Supply)	Retail Co-payment/Coinsurance (90 day Supply)	Mail-Order Co-payment/Coinsurance (30-day supply)	Mail-Order Co-payment/Coinsurance (90-day supply)	Out of Network Co-payment/Coinsurance (30 day Supply)
Preferred Generic	15%	15%	15%	15%	15%
Preferred Brand	30%	30%	30%	30%	30%
Non-Preferred Generic/Brand	50%	50%	50%	50%	50%

Once your total drug costs reach \$2,700, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

Coverage Gap

After your total drug costs reach \$2,700 you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach \$4,350, and you qualify for catastrophic coverage.

Once your total out-of-pocket costs reach \$4,350, you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,350 out-of-pocket for the year. When the total amount you have paid toward your deductible, coinsurance and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of 5% coinsurance or \$2.40 for generics or drugs that are treated like generics and \$6.00. We will pay the rest.

Additional Benefits Information

Vaccine Coverage (including administration)

Our Plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance/co-payment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during the deductible or coverage gap phases of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance for the vaccine (including administration)
The Pharmacy	Your Doctor	You pay your normal coinsurance for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less

		any applicable in-network charge for administering the vaccine
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*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Customer Service.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your annual deductible;
- Your coinsurance up to the initial coverage limit
- Any payments you make for drugs in the coverage gap
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of \$4,350 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and

- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan’s benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.]



General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, and drugs that aren’t covered (“are excluded”) or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren’t covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items or drugs that are not covered, you must pay for them yourself

We won’t pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services aren’t covered under the Original Medicare Plan or by our plan:**

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered. However, these items are available under the Optional Dental Supplemental Benefit.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids.
20. Eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Excluded Drugs

This part of Section 10 talks about drugs that are “excluded,” meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in [Section 5](#)).

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

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