Group Health
Certificate of Coverage

City of Seattle – Retirees
Clear Care Plan

January 1, 2009

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

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Benefit Booklet
Table of Contents

Section I. Introduction
A. Accessing Care
B. Cost Shares
C. Subscriber's Liability
D. Claims

Section II. Allowances Schedule

Section III. Eligibility, Enrollment and Termination
A. Eligibility
B. Enrollment
C. Effective Date of Enrollment
D. Eligibility for Medicare
E. Termination of Coverage
F. Services After Termination of Agreement
G. Continuation of Coverage Options

Section IV. Schedule of Benefits
A. Hospital Care
B. Medical and Surgical Care
C. Chemical Dependency Treatment
D. Plastic and Reconstructive Services
E. Home Health Care Services
F. Hospice Care
G. Rehabilitation Services
H. Devices, Equipment and Supplies
I. Tobacco Cessation
J. Drugs, Medicines, Supplies and Devices
K. Mental Health Care Services
L. Emergency/Urgent Care
M. Ambulance Services
N. Skilled Nursing Facility

Section V. General Exclusions

Section VI. Grievance Processes for Complaints and Appeals

Section VII. General Provisions
A. Coordination of Benefits
B. Subrogation and Reimbursement Rights
C. Miscellaneous Provisions

Section VIII. Definitions

Attachment: Group Medicare Coverage

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 $100 Copayment per day up to a maximum of three (3) days per Member per admission; no Copayment on additional days thereafter.

- 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 $1,000 per Member and $2,000 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 $50 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 $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.

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 $250 maximum during any consecutive twenty-four (24) 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 twenty-four (24) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the lesser of GHC's charge or the applicable outpatient services Cost Share as often as Medically Necessary.

- Lenses, including contact lenses, and frames

  Lenses: One pair of standard single vision, lenticular, non-blended bifocal or trifocal lenses, or contact lenses, including exams associated with their fitting, in lieu of standard eyeglass lenses and frames covered up to the following Allowance:

  Single vision lenses - maximum $75 allowance.
  Bifocal lenses - maximum $118 allowance.
  Trifocal or lenticular - maximum $118 allowance.
  One pair of cosmetic contact lenses, including exams associated with their fitting, covered with a $135 maximum allowance.

  Frames: Covered up to $100 per twenty-four (24) month period per Member.

The benefit period begins on the date services are first obtained and continues for twenty-four (24) months.

- One pair of eyeglasses or contact lenses following cataract surgery - Covered in full. Replacements lenses are not covered. Contact lenses for other eye pathologies are covered in full.

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.

   1) GHC will allow special enrollment for persons:
      a) 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
      b) 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.

   2) 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 twenty-four (24) months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered as often as necessary upon recommendation of a GHC Provider.

    Contact lenses for eye pathology, including contact lens exam and fitting, are covered. 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 lenses are not covered.

    Lenses. One pair of prescription single vision, lenticular, or nonblended bifocal or trifocal lenses and frames, or contact lenses, including examinations and fittings, for cosmetic purposes in lieu of lenses and frames, will be covered when purchased at a Group Health-owned or contracted optical hardware provider subject to the Allowance set forth in the Allowances Schedule.

    Frames. Frames will be covered when purchased at a Group Health-owned or contracted optical hardware provider subject to an Allowance set forth in the Allowances Schedule. Any expense beyond this Allowance is the responsibility of the Member.

    Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures; sunglasses and industrial and athletic safety frames and lenses.

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		
1 - Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	For each benefit period: Days 1 - 60: $1,024 deductible. Days 61 - 90: $256 per day. Days 91 - 150: $512 per lifetime reserve day. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	**In-Network:** For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments: Days 1-5: $200 copay per day Days 6-90: $0 copay per day $0 copay for additional hospital days. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
2 - Inpatient Mental Health Care	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.	For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments: Days 1-5: $200 copay per day Days 6-90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime.

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)	For each benefit period after at least a 3-day covered hospital stay: Days 1 - 20: $0 per day. Days 21 - 100: $128 per day. 100 days for each benefit period. 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.	There is no copayment for services received at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Prior authorization is required
4 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay	Authorization rules may apply. $0 copay for Medicare-covered home health visits.
5 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	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	**General** See "Routine Physical Exams" for more information. Authorization rules may apply. **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. You pay the lesser of the Group cost share or $20 copay for each specialist visit for Medicare-covered services.
7 - Chiropractic Services	20% coinsurance Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractors or other qualified provider. You pay 100% for routine care.	**In-Network** You pay the lesser of the Group cost share or $20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
8 - Podiatry Services	20% coinsurance Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $20 copay for Medicare-covered visits. Medicare-covered podiatry benefits are for medically-necessary foot care.

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
18 - Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $0 copay for Diabetes self-monitoring training. You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered Diabetes Supply items.
19 - Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services 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.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: • *lab services* • *diagnostic procedures and tests* • X-rays • Diagnostic radiology services (not including X-rays) • therapeutic radiology services
PREVENTIVE SERVICES		
20 - Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**General** Authorization rules may apply. **In-Network** $0 copay
21 - Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	**General** Authorization rules may apply.

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

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