City of Seattle Deductible Plan

Most Employees

Summary Plan Description

January 1, 2015

GroupHealth®

Important Notice Under Federal Health Care Reform

Group Health recommends each Member choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Member's health care. The Member has the right to designate any Network Personal Physician who participates in one of the Group Health networks and who is available to accept the Member or the Member's family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

For children, the Member may designate a pediatrician as the primary care provider.

The Member does not need Preauthorization from Group Health or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the Group Health network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

For More Information

Group Health will provide the information regarding the types of plans offered by Group Health to Members on request. Please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, 1-888-901-4636.

Table of Contents

I. Introduction 6
II. Medical Plan 6
III. Eligibility, Enrollment and Termination 6
A. Eligibility. 6
B. Application for Enrollment. 7
C. When Coverage Begins. 8
D. Termination of Coverage. 9
E. Continuation of Inpatient Services. 10
F. Continuation of Coverage Options. 10
G. Qualified Medical Child Support Orders (QMCSOs). 11
H. Cafeteria Plan Rules. 11
IV. How Covered Services Work 11
A. Accessing Care. 11
B. Administration of the Summary Plan Description. 13
C. Confidentiality. 13
D. Modification of the Plan. 13
E. Nondiscrimination. 13
F. Pre-existing Condition Waiting Period. 14
G. Preauthorization. 14
H. Recommended Treatment. 14
I. Second Opinions. 14
J. Unusual Circumstances. 14
K. Utilization Management. 14
V. Financial Responsibilities 14
A. Financial Responsibilities for Covered Services. 15
B. Financial Responsibilities for Non-Covered Services. 15
VI. Benefits Details 16
Annual Deductible 16
Coinsurance 16
Lifetime Maximum 16
Out-of-pocket Limit 16
Pre-existing Condition Waiting Period 16
Acupuncture 17
Allergy Services 17
Ambulance 17
Cancer Screening and Diagnostic Services 17
Chemical Dependency 17
Circumcision 19
Clinical Trials 19
Dental Services and Dental Anesthesia 19
Devices, Equipment and Supplies (for home use) 20
Diabetic Education, Equipment and Pharmacy Supplies 20
Diagnostic Laboratory and Radiology 21
Dialysis (Home and Outpatient) 21

Drugs - Outpatient Prescription 21
Emergency Services 23
Hearing Examinations and Hearing Aids 24
Home Health Care 24
Hospice 25
Hospital - Inpatient and Outpatient 26
Infertility (including sterility) 27
Manipulative Therapy 27
Maternity and Pregnancy 27
Mental Health 28
Naturopathy 29
Newborn Services 30
Nutritional Counseling 30
Nutritional Therapy 30
Obesity Related Services 30
On the Job Injuries or Illnesses 31
Oncology 31
Optical (vision) 31
Oral Surgery 32
Outpatient Services 32
Plastic and Reconstructive Surgery 32
Podiatry 33
Preventive Services 33
Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy) and Neurodevelopmental Therapy 34
Sexual Dysfunction 35
Skilled Nursing Facility 35
Sterilization 35
Telehealth 36
Temporomandibular Joint (TMJ) 36
Tobacco Cessation 36
Transgender Services 37
Transplants 37
Urgent Care 38

VII. General Exclusions 38
VIII. Grievances 40
IX. Appeals 40
X. Claims 41
XI. Coordination of Benefits 42
A. Definitions 42
B. Order of Benefit Determination Rules. 44
C. Effect on the Benefits of this Plan. 45
D. Right to Receive and Release Needed Information. 45
E. Facility of Payment. 45
F. Right of Recovery. 46
G. Effect of Medicare 46

XII. Subrogation and Reimbursement Rights 46
XIII. Definitions 47
XIV. Plan Administration and Legal Rights 51
XV. Plan Identification Data 55

I. Introduction

This plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Group Health Customer Service toll free 1-888-901-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor toll free 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

This booklet includes information about medical benefits available under the City of Seattle's Group Health Plan ("Plan") to eligible staff and their family members and serves as the Summary Plan Description for medical, pharmacy and optical benefits.

II. Medical Plan

City of Seattle's Group Health Plan is designed to provide health benefits for City of Seattle's employees and their eligible family members. Questions about eligibility for health coverage can be answered by City of Seattle.

This document describes the health benefits offered under the Plan. The health benefits are administered by Group Health Cooperative (Group Health). If you have questions regarding your coverage or how benefits have been paid, Group Health encourages you to contact the Group Health Customer Service Center at 206-901-4636 or toll free 888-901-4636.

Please take the time to become familiar with the benefits that the Plan offers. Many terms used in this booklet have specific meanings that are defined in the Definitions section.

III. Eligibility, Enrollment and Termination

A. Eligibility.

In order to be accepted for enrollment and continuing coverage, individuals must meet any eligibility requirements imposed by the Plan Administrator, 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 the Plan Administrator. Group Health has the right to verify eligibility.

1. Subscribers.

An active, regular full-time employee who works at least 80 hours per month or a temporary employee in a benefits-eligible assignment who works at least 80 hours per month is eligible to obtain City of Seattle-paid contributions for coverage. A temporary employee who has worked at least 1,040 cumulative, non-overtime hours and at least 800 non-overtime hours in the previous 12 month period, and is not in a benefits-eligible assignment is eligible for coverage.

An employee for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the 15th of the month will not have a lapse in coverage. Coverage for an employee who returns after the 15th of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for 15 consecutive calendar days or less will not have a lapse in coverage.

2. Dependents.

The employee may also enroll the following:

a. The s employee's legal spouse (unless legally separated) or state-registered domestic partner as required by Washington state law;

b. The employee's domestic partner, other than a state-registered domestic partner, provided that the employee and domestic partner:
   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 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 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. Children who are under the age of 26.

"Children" means the children of the employee or spouse, including adopted children, stepchildren, children of a domestic partner, or state-registered domestic partner, children for whom the employee has a qualified court order to provide coverage and any other children for whom the employee 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 employee 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 Group Health upon request, but not more frequently than annually after the 2 year period following the Dependent's attainment of the limiting age.

3. Temporary Coverage for Newborns.
When a Member gives birth, the newborn is entitled to the benefits set forth in the Summary Plan Description from birth through 3 weeks of age. All provisions, limitations and exclusions will apply except Subsections E. and F. After 3 weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

B. Application for Enrollment.
Application for enrollment must be completed on or before the effective date of coverage. The Plan Administrator is responsible for submitting completed applications to Group Health.

Group Health reserves the right to refuse enrollment to any person whose coverage under any plan issued by Group Health Options, Inc. or Group Health Cooperative has been terminated for cause.

1. Newly Eligible Employees.
Newly eligible employees and their Dependents may apply for enrollment in writing to the Plan Administrator within 31 days of becoming eligible.

Temporary employees and their Dependents who are not in a benefits-eligible assignment may apply for enrollment in writing to the Group within 90 days of becoming eligible.

2. New Dependents.
A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Plan Administrator within 31 days after the dependency occurs.

A written application for enrollment of a newborn child must be made to the Plan Administrator within 60 days following the date of birth.

A written application for enrollment of an adoptive child must be made to the Plan Administrator within 60 days from the day the child is placed with the employee for the purpose of adoption or the employee assumes total or partial financial support of the child.

3. Open Enrollment.
Group Health will allow enrollment of employees and Dependents who did not enroll when newly eligible as described above during a limited period of time specified by the Plan Administrator and Group Health.

4. Special Enrollment.

a. Group Health will allow special enrollment for persons:
   1) 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.
   2) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and who have had such other coverage exhausted because such person reached a lifetime maximum limit.

   Group Health or the Plan Administrator may require confirmation that when initially offered coverage such persons submitted a written statement declining because of other coverage. Application for coverage must be made within 31 days of the termination of previous coverage.

b. Group Health will allow special enrollment for individuals who are eligible to be an employee and his/her Dependents in the event one of the following occurs:
   1) Marriage. Application for coverage must be made within 31 days of the date of marriage.
   2) Birth. Application for coverage for the employee and Dependents other than the newborn child must be made within 60 days of the date of birth.
   3) Adoption or placement for adoption. Application for coverage for the employee and Dependents other than the adopted child must be made within 60 days of the adoption or placement for adoption.
   4) Eligibility for premium assistance from Medicaid or a state Children's Health Insurance Program (CHIP), provided such person is otherwise eligible for coverage under this Plan. The request for special enrollment must be made within 60 days of eligibility for such premium assistance.
   5) Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP.
   6) Applicable federal or state law or regulation otherwise provides for special enrollment.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- City of Seattle-paid enrollment for a newly eligible Subscriber and listed Dependents will begin on the Subscriber's 1st day of employment if that date is: (a) the 1st calendar day of the month designated as a City of Seattle business day, or (b) the 1st calendar day of the month designated/recognized as the 1st working day for the shift to which the Subscriber is assigned, whichever is later. If employment begins after said date, the Subscriber's enrollment will begin the following month.
- Enrollment on a self-pay basis, for a newly eligible Subscriber and listed Dependents will begin on the 1st day of the month following the date the application is received.
- Enrollment for temporary employees who are not in a benefits-eligible assignment will begin the 1st of the calendar month following the date application is made and the rate is paid, or the date designated by the Group if application is made during an open enrollment period. Enrollment for temporary employees in a benefits-eligible assignment will begin the 1st calendar day of the month designated as

a City of Seattle business day. If employment begins after said date, enrollment for the temporary employee in a benefits eligible assignment will begin the following month.

- 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 1st of the month following application.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children, children placed for adoption, or children for whom the Subscriber becomes a legal guardian is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption, or from the date of legal guardianship, and the Subscriber has assumed 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 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-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network 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 Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. Termination of Coverage.
The employee shall be liable for payment of all charges for services and items provided to the employee and all Dependents after the effective date of termination.

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 and is not enrolled for continuation coverage as described in Subsection F. below, coverage will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Plan Administrator.

b. For Cause. In the event of termination for cause, Group Health reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses or other damages. Coverage of a Member may be terminated upon 10 working days written notice for:
   1.) Material misrepresentation, fraud or omission of information in order to obtain coverage.
   2.) Permitting the use of a Group Health 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.

c. Premium Payments. Nonpayment of premiums or contribution for a specific Member by the group.

Individual Member coverage may be retroactively terminated upon 30 days written notice and only in the case of fraud or intentional misrepresentation of a material fact; or as otherwise allowed under applicable law or regulation.

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 Plan.

Any Member may appeal a termination decision through Group Health's appeals process.

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

E. Continuation of Inpatient Services.

A Member who is receiving Covered Services 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 Group Health clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The Member becomes covered under another plan with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under a plan with another carrier that provides benefits for the hospitalization.

This provision will not apply if the Member is covered under another plan 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 F. below.

F. 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.D.) 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. Leave of Absence.

While on an employer approved leave of absence, the employee and listed Dependents can continue to be covered provided that:

- They remain eligible for coverage, as set forth in Subsection A.,
- Such leave is in compliance with the employer's established leave of absence policy that is consistently applied to all employees,
- The employer's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable.

3. Self-Payments During Labor Disputes.

In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, an employee may continue uninterrupted coverage through self-payment directly to the employer. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for 6 months after the cessation of work.

If coverage under the Plan is no longer available, the employee shall have the opportunity to apply for an individual Group Health group conversion plan or, if applicable, continuation coverage (see Subsection 4. below), or an individual and family plan at the duly approved rates.

The employer is responsible for immediately notifying each affected employee of his/her rights of self-payment under this provision.

4. Continuation Coverage Under 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 or the Uniformed Services Employment and Reemployment Rights Act (USERRA) and only applies to grant continuation of coverage rights to the extent required by federal law. USERRA only applies in certain situations to employees who

are leaving employment to serve in the United States Armed Forces. The employer shall inform Members of the COBRA election process and how much the Member will be required to pay directly to the employer.

Continuation coverage under COBRA or USERRA will terminate when a Member becomes covered by Medicare or obtains other group coverage, and as set forth under Subsection D.

5. Group Health Group Conversion Plan.

Members whose eligibility for coverage, including continuation coverage, is terminated for any reason other than cause, as set forth in Subsection D., and who are not eligible for Medicare or covered by another group health plan, may convert to an individual Group Health group conversion plan. If coverage under the Plan terminates, any Member covered at termination may convert to a Group Health group conversion plan, unless he/she is eligible to obtain other group health coverage within 31 days of the termination.

An application for conversion must be made within 31 days following termination of coverage or within 31 days from the date notice of the termination of coverage is received, whichever is later. A physical examination or statement of health is not required for enrollment in a Group Health group conversion plan.

By exercising group conversion rights, the Member may waive guaranteed issue and pre-existing condition waiver rights under Federal regulations.

Persons wishing to purchase Group Health's individual and family coverage should contact Group Health.

G. Qualified Medical Child Support Orders (QMCSOs).

Members and Dependents can obtain, without charge, a copy of the Plan's procedures on QMCSOs from the City of Seattle.

H. Cafeteria Plan Rules.

For eligible programs, employees may make pre-tax salary elections to pay for benefits through the employer-provided cafeteria plan. For more information please see City of Seattle.

IV. How Covered Services Work

Group Health is contracted by City of Seattle to perform health plan administrative services and to arrange for the delivery of health care services only and does not assume any financial risk or obligation with respect to claims.

Read This Summary Plan Description Carefully

This Summary Plan Description is a statement of benefits, exclusions and other provisions of the Plan.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Benefits Details section and the General Exclusions. These sections must be considered together to fully understand the benefits available under the Plan. Words with special meaning are capitalized. They are defined in the Definitions section.

A. Accessing Care.

1. Members are entitled to Covered Services from the following:

Members are entitled to Covered Services only at Network Facilities and from Network Providers, except for Emergency services and care pursuant to a Preauthorization.

A listing of Network Personal Physicians, specialists, women's health care providers and Group Health-designated Specialists is available by contacting Customer Service or accessing the Group Health website at www.ghc.org.

2. Primary Care Provider Services.

Group Health recommends that Members select a Network Personal Physician when enrolling. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating personal physicians, call the Group Health Customer Service Center at (206)901-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 or by accessing the Group Health website at www.ghc.org. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. If a personal physician accepting new Members is not available in your area, contact the Group Health Customer Service Center, who will ensure you have access to a personal physician by contacting a physician's office to request they accept new Members.

In the case that the Member's personal physician no longer participates in Group Health's network, the Member will be provided access to the personal physician for up to 60 days following a written notice offering the Member a selection of new personal physicians from which to choose.

3. Specialty Care Provider Services.

Unless otherwise indicated, Preauthorization is required for specialty care and specialists that are not Group Health-designated Specialists and are not providing care at facilities owned and operated by Group Health.

Group Health-designated Specialist.

Members may make appointments with Group Health-designated Specialists at facilities owned and operated by Group Health without Preauthorization. To access a Group Health-designated Specialist, consult your Group Health personal physician, contact Customer Service for a list of Group-Health-designated Specialists, or view the Provider Directory located at www.ghc.org. The following specialty care areas are available from Group Health-designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, 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.

4. Hospital Services.

Non-Emergency inpatient hospital services require Preauthorization. Refer to the Benefits Details section for more information about hospital services.

5. Emergency Services.

Emergency services at a Network Facility or non-Network Facility are covered. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Coverage for Emergency services at a non-Network Facility is limited to the Allowed Amount. Refer to the Benefits Details section for more information about Emergency services.

6. Urgent Care.

Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Outside the Group Health Service Area, urgent care is covered at any medical facility. Refer to the Benefits Details section for more information about urgent care.

7. Women's Health Care Direct Access Providers.

Female Members may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (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 Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Member's women's health care provider

diagnoses a condition that requires other specialists or hospitalization, the Member or her chosen provider must obtain Preauthorization in accordance with applicable Group Health requirements.

8. Process for Medical Necessity Determination.
Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

First Level Review:

First level reviews are performed or overseen by appropriate clinical staff using Group Health approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the Member's medical record, and consultation with the attending/referring physician and multidisciplinary health care team. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The Member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the requesting physician when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second Level (Practitioner) Review:

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the requesting physician when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

B. Administration of the Summary Plan Description.
Group Health may adopt reasonable policies and procedures to administer the Plan. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

C. Confidentiality.
Group Health is required by federal and state law to maintain the privacy of Member personal and health information. Group Health is required to provide notice of how Group Health may use and disclose personal and health information held by Group Health. The Notice of Privacy Practices is distributed to Members and is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.

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

E. Nondiscrimination.
Group Health does not discriminate on the basis of physical or mental disabilities in its employment practices and services. Group Health will not refuse to enroll or terminate a Member's coverage on the basis of age, sex, race, religion, occupation or health status.

F. Pre-existing Condition Waiting Period.

Pre-existing conditions are covered with no waiting period. A pre-existing condition is a condition for which there has been diagnosis, treatment or medical advice within the 3 month period prior to the effective date of coverage.

G. Preauthorization.

Covered Services may require Preauthorization. Refer to the Benefits Details section for more information. Group Health recommends that the provider requests Preauthorization. Members may also contact Customer Service. Preauthorization requests are reviewed and approved based on Medical Necessity, eligibility and benefits.

H. Recommended Treatment.

Group Health's medical director 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 services to the extent permitted by law. Members who obtain care not recommended by Group Health's medical director do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care. Coverage decisions may be appealed.

I. Second Opinions.

The Member may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member may request Preauthorization or may visit a Group Health-designated Specialist for a second opinion. When requested or indicated, second opinions are provided by Network Providers and are covered with Preauthorization, or when obtained from a Group Health-designated Specialist. Coverage is determined by the Member's Plan; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Preauthorization for a second opinion does not imply that Group Health will authorize the Member to return to the physician providing the second opinion for any additional treatment. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the Plan.

J. Unusual Circumstances.

In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, Group Health will not be liable for administering coverage beyond the limitations of available personnel and facilities.

In the event of unusual circumstances such as those described above, Group Health will make a good faith effort to arrange for Covered Services through available Network Facilities and personnel. Group Health shall have no other liability or obligation if Covered Services are delayed or unavailable due to unusual circumstances.

K. Utilization Management.

All benefits are limited to Covered Services that are Medically Necessary and set forth in the Plan. Group Health may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, Group Health may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria.

Group Health will not deny coverage retroactively for services with Preauthorization and which have already been provided to the Member except in the case of an intentional misrepresentation of a material fact by the patient, Member, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application, or for nonpayment of premiums.

V. Financial Responsibilities

A. Financial Responsibilities for Covered Services.

The employee is liable for the following Cost Shares when services are received by the employee and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the employee during each year until the annual Deductible is met. Covered Services must be received from a Network Provider at a Network Facility, unless the Member has received Preauthorization or has received Emergency services.

There is an individual annual Deductible amount for each Member and a maximum annual Deductible amount for each Family Unit. Once the annual Deductible amount is reached for a Family Unit in a calendar year, the individual annual Deductibles are also deemed reached for each Member during that same calendar year.

2. Plan Coinsurance.

After the applicable annual Deductible is satisfied, Members may be required to pay Plan Coinsurance for Covered Services.

3. Copayments.

Members shall be required to pay applicable Copayments at the time of service. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service or if other Cost Shares apply.

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in the Benefits Details section. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit.

B. Financial Responsibilities for Non-Covered Services.

The cost of non-Covered Services and supplies is the responsibility of the Member. The employee is liable for payment of any fees charged for non-Covered Services provided to the employee and his/her Dependents at the time of service. Payment of an amount billed must be received within 30 days of the billing date.

VI. Benefits Details

Benefits are subject to all provisions of the Plan. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by Group Health's medical director and as described herein. All Covered Services are subject to case management and utilization management at the discretion of Group Health.

Annual Deductible	Member pays $200 per Member per calendar year or $600 per Family Unit per calendar year
Coinsurance	**Plan Coinsurance:** No Plan Coinsurance
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	Limited to a maximum of $2,000 per Member or $6,000 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: Ambulance coinsurance/Copayment, Emergency services Copayment, hospital outpatient Copayment, outpatient services Copayment **The following expenses do not apply to the Out-of-pocket Limit:** Annual Deductible, benefit-specific coinsurances, prescription drug Copayment, premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period

Acupuncture	
Acupuncture needle treatment. Limited to 8 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. No visit limit for treatment for Chemical Dependency.	After Deductible, Member pays $15 Copayment
Exclusions: Herbal supplements; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	After Deductible, Member pays $15 Copayment
Allergy serum and injections.	After Deductible, Member pays $15 Copayment

Ambulance	
Emergency ground or air transport to any facility.	Member pays 20% ambulance coinsurance
Non-Emergency ground or air interfacility transfer to or from a Network Facility when initiated by Group Health.	Member pays 20% ambulance coinsurance **Hospital-to-hospital ground transfers:** No charge; Member pays nothing

Cancer Screening and Diagnostic Services	
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service. See Preventive Services for additional information.	Member pays $15 Copayment
Diagnostic laboratory and diagnostic services for cancer. See Diagnostic Laboratory and Radiology Services for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Member pays nothing

Chemical Dependency	
Chemical dependency services including inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under the Plan.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Outpatient Services:** After Deductible, Member

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 services must be provided at a Group Health-approved treatment facility or treatment program. Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. Court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary. Residential Treatment and non-Emergency inpatient hospital services require Preauthorization.	pays $15 Copayment
Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "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 (detoxification) is provided without Preauthorization. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Group Health reserves the right to require transfer of the Member to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Member refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.	**Emergency Services Network Facility:** After Deductible, Member pays $100 Copayment **Emergency Services Non-Network Facility:** After Deductible, Member pays $150 Copayment **Hospital - Inpatient:** After Deductible, Member pays nothing

Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatment programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State

Circumcision	
Circumcision. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment

Clinical Trials	
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis	

Dental Services and Dental Anesthesia	
Dental services including accidental injury to natural teeth.	Not covered; Member pays 100% of all charges
General anesthesia services and related facility charges for dental procedures for Members who are under 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. General anesthesia services for dental procedures require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment
Exclusions: Dentist's or oral surgeon's fees; 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; any other dental service not specifically listed as covered

Devices, Equipment and Supplies (for home use)	
• Durable medical equipment: 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 is used in the Member's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. Group Health will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras, limited to 2 every 6 months. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Orthotic devices • Breast pump rental and one supply kit When provided in lieu of hospitalization, 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. Devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.	Member pays 20% coinsurance Orthotics: Limited to an Allowance of $500 maximum per lifetime. After Allowance; Not covered; Member pays 100% of all charges Breast Pump: No charge; Member pays nothing. Rental limited to 6 months maximum, once per pregnancy. Includes lactation counseling, post-delivery health education classes, and home visits by a trained lactation consultant
Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's home or personal vehicle	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	After Deductible, Member pays $15 Copayment
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic	Member pays 20% coinsurance

shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less. See Drugs – Outpatient Prescription for additional pharmacy information. Certain brand name insulin drugs will be covered at the generic level.	**Preferred generic drugs (Tier 1):** Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** Not covered; Member pays 100% of all charges
Diabetic retinal screening.	No charge; Member pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Members with end-stage renal disease (ESRD). Dialysis requires Preauthorization.	**Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Injections administered by a professional in a clinical setting during dialysis.	**Outpatient Services:** After Deductible, Member pays $15 Copayment
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $15 Copayment **Preferred brand name drugs y (Tier 2):** Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** Not covered; Member pays 100% of all charges

Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), contraceptive drugs and devices, mental health drugs, self-administered injectables, and routine costs for prescription medications provided in a clinical trial. ”Routine costs” means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. All drugs, supplies and devices must be obtained at a Group	**Preferred generic drugs (Tier 1):** Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** Not covered; Member pays 100% of all charges

Health-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the Group Health Service Area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory, or can be obtained by contacting the Group Health Customer Service Center. Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.ghc.org.	
Injections administered by a professional in a clinical setting.	After Deductible, Member pays $15 Copayment
Over-the-counter drugs.	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the Group Health-designated mail order service	Member pays 2 times the prescription drug Copayment for each 90 day supply or less

The Group Health Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.ghc.org, or upon request from Customer Service.

Members may request a coverage determination by contacting Customer Service. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits. If coverage of a non-Preferred drug is approved, the drug will be covered at the Preferred drug level.

Prescription drugs 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) are covered. “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 health care 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.

Generic drugs are dispensed whenever available. A generic drug is 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. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when a Member tries

a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs.
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 and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact Group Health at 206-901-4636 or toll-free 1-888-901-4636 or by accessing the Group Health website at www.ghc.org. 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 Plan, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.
Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.
Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations; drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; vitamins, including most prescription vitamins; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See the Definitions section for a definition of Emergency. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. If a Member is admitted as an inpatient directly from a Network Facility emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. 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 Emergency services Copayment. If a Member is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility upon consultation between a Network Provider and the attending physician. If the Member refuses to transfer to a Network Facility or does not notify Group Health within 24 hours following admission, all further costs	**Network Facility:** After Deductible, Member pays $100 Copayment **Non-Network Facility:** After Deductible, Member pays $150 Copayment

incurred during the hospitalization are the responsibility of the Member. Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.	

Hearing Examinations and Hearing Aids	
Cochlear implants when in accordance with Group Health clinical criteria. Covered services for cochlear implants include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at Group Health-approved facilities.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Hearing aids including hearing aid examinations.	Member pays nothing, limited to an Allowance of $1,000 maximum per ear during any consecutive 36 month period After Allowance: Not covered; Member pays 100% of all charges
Exclusions: Programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing aids or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services; replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the benefit Allowance; repairs; replacement parts; replacement batteries; maintenance costs	

Home Health Care	
Home health care when the following criteria are met: • 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. • The Member requires intermittent skilled home health care, as described below. • Group Health's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a Group Health-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech	No charge; Member pays nothing

therapy; durable medical equipment; 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. "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. Home health care requires Preauthorization.	
Exclusions: Private duty nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above	

Hospice	
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. **Inpatient Hospice Services.** For short-term care, inpatient hospice services are covered with Preauthorization. Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member for a maximum of 5 consecutive days per occurrence. **Other covered hospice services may include the following:** • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment when billed by a licensed hospice care program. Hospice care requires Preauthorization.	No charge; Member pays nothing
Exclusions: Private duty nursing, financial or legal counseling services; meal services; any services provided by	

family members

Hospital - Inpatient and Outpatient	
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). Outpatient hospital includes ambulatory surgical centers. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. 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. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization. Members receiving the following nonscheduled services are required to notify Group Health by way of the Group Health Hospital Notification Line within 24 hours following any admission, or as soon thereafter as medically possible: acute chemical withdrawal (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained. Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that have not been approved by Group Health's medical director	

Infertility (including sterility)	
General counseling and diagnostic services.	Not covered; Member pays 100% of all charges
Specific diagnostic services, treatment and prescription drugs.	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sterility and infertility regardless of origin or cause; all charges and related services for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; prognostic (predictive) genetic testing for the detection of congenital and heritable disorders; surrogacy	

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.	After Deductible, Member pays nothing

Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with Group Health clinical criteria, limited to a total of 10 visits per calendar year.	After Deductible, Member pays $15 Copayment
Exclusions: 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; charges for any other services that do not meet Group Health clinical criteria as Medically Necessary	

Maternity and Pregnancy	
Maternity care and pregnancy services, including care for complications of pregnancy and prenatal and postpartum care are covered for all female members including dependent daughters. Delivery and associated Hospital Care, including home births and birthing centers. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment Any applicable Deductible is waived for routine

admission, or as soon thereafter as medically possible. The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery. Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by Group Health's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.	prenatal and postpartum visits
Termination of pregnancy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications	

Mental Health	
Mental health services, limited to when the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention as determined by Group Health's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health services including medical management and prescriptions are covered the same as for any other condition. Outpatient electro-convulsive therapy treatment is covered subject to the hospital-outpatient Cost Share. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by Group Health's medical director. Services provided under involuntary commitment statutes are covered only at Group Health-approved facilities. Coverage for voluntary/involuntary Emergency inpatient	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment

psychiatric services is subject to the Emergency services benefit. Coverage for services incurred at non-Network Facilities shall exclude any charges that would otherwise be excluded for hospitalization within a Network Facility. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. Inpatient mental health services must be provided at a hospital or facility that Group Health has approved specifically for the treatment of mental or nervous disorders. Non-Emergency inpatient hospital services require Preauthorization.	
Exclusions: Academic or career counseling; personal growth or relationship enhancement; 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; specialty treatment programs such as "behavior modification programs"; relationship counseling or phase of life problems (V code only diagnoses); custodial care	

Naturopathy	
Naturopathy. Limited to 3 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. Laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Member pays $15 Copayment
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure	

Newborn Services	
Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother. Preventive services for newborns are covered under Preventive Services. See the Eligibility, Enrollment and Termination section for information about coverage for newborns.	**Hospital - Inpatient:** After Deductible, Member pays nothing During the baby's initial hospital stay while the birth mother and baby are both confined, any applicable Deductible and Copayment for the newborn are waived **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment

Nutritional Counseling	
Nutritional counseling.	After Deductible, Member pays $15 Copayment
Exclusions: Nutritional supplements; weight loss programs; pre and post bariatric surgery nutritional counseling	

Nutritional Therapy	
Dietary formula for the treatment of phenylketonuria (PKU).	No charge; Member pays nothing
Enteral therapy (elemental formulas) for malabsorption. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 20% coinsurance
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays nothing
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements; special diets; prepared foods/meals and formula for access problems	

Obesity Related Services	
Bariatric surgery and related hospitalizations when Group Health criteria are met. Obesity related services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member

	pays $15 Copayment
Exclusions: All other obesity treatment and treatment for morbid obesity including any medical services, drugs or supplies, regardless of co-morbidities; specialty treatment programs such as weight reduction for any reason; medications and related physician visits for medication monitoring; pre and post bariatric surgery nutritional counseling	

On the Job Injuries or Illnesses	
On the job injuries or illnesses.	**Hospital - Inpatient:** Not covered; Member pays 100% of all charges **Hospital - Outpatient:** Not covered; Member pays 100% of all charges **Outpatient Services:** Not covered; Member pays 100% of all charges
Exclusions: Confinement, treatment or service that results from an illness or injury arising out of or in the course of any employment for wage or profit including injuries, illnesses or conditions incurred as a result of self-employment	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy.	**Radiation Therapy and Chemotherapy:** After Deductible, Member pays $15 Copayment **Oral Chemotherapy Drugs**: **Preferred generic drugs (Tier 1):** Member pays $15 Copayment **Preferred Brand name drugs (Tier 2):** Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** Not covered; Member pays 100% of all charges

Optical (vision)	
Routine eye examinations and refractions, limited to once every 12 months. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions, as often as Medically Necessary.	**Routine Exams:** Member pays $15 Copayment **Exams for Eye Pathology:** After Deductible, Member pays $15 Copayment

Contact lenses for eye pathology. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by Group Health since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription.	**Frames and Lenses:** Not covered; Member pays 100% of all charges **Contact Lenses for Eye Pathology:** After Deductible, Member pays nothing
Exclusions: Eyeglasses; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Oral Surgery	
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. Group Health's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services. Oral surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature	

Outpatient Services	
Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management. See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.	After Deductible, Member pays $15 Copayment

Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member

resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of Group Health's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are 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. Plastic and reconstructive surgery requires Preauthorization.	pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services	

Podiatry	
Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and, when approved by Group Health's medical director, other clinical conditions that effect sensation and circulation to the feet.	After Deductible, Member pays $15 Copayment
Exclusions: All other routine foot care not related to the treatment of diabetes	

Preventive Services	
Preventive services in accordance with the well care schedule established by Group Health. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF). Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Preventive services include, but are not limited to, well adult	Member pays $15 Copayment

and well child physical examinations; immunizations and vaccinations; pap smears; routine mammography screening; and routine prostate screening and colorectal cancer screening for Members who are age 50 or older or who are under age 50 and at high risk. Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the Group Health well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	
Exclusions: Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes that are not deemed Medically Necessary by Group Health for early detection of disease; diagnostic services	

Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy) and Neurodevelopmental Therapy	
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. 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. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist. Habilitative care, including: occupational therapy, physical therapy, speech therapy is covered when prescribed by a Group Health physician. Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Member's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care and Neurodevelopmental Therapy services.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Outpatient Services:** After Deductible, Member pays $15 Copayment

Non-Emergency inpatient hospital services and massage therapy require Preauthorization.	
Exclusions: Specialty treatment programs such as cardiac rehabilitation; inpatient Residential Treatment services; specialty rehabilitation programs including “behavior modification programs”; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member’s level of functioning (except as described for neurodevelopmental therapy); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs	

Sexual Dysfunction	
Sexual dysfunction services.	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sexual dysfunction regardless of origin or cause; devices, equipment and supplies for the treatment of sexual dysfunction	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 60 days per calendar year. 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 restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Member pays nothing
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
Female sterilization procedures. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment

Vasectomy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Procedures and services to reverse a sterilization	

Telehealth	
Telehealth (audio and video communication) services between a consulting distant site provider, and the originating site provider, where the Member is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.	**Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services; the site fee from the originating location	

Temporomandibular Joint (TMJ)	
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
TMJ appliances. See Devices, Equipment and Supplies for additional information.	Member pays 20% coinsurance
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea; hospitalizations related to these exclusions	

Tobacco Cessation	
Individual/group counseling and educational materials.	No charge; Member pays nothing **Other outpatient services:** After Deductible,

	Member pays $15 Copayment
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	**Group Health-designated tobacco cessation program:** No charge; Member pays nothing for each 30 day supply or less when prescribed by a Group Health provider and obtained at a Group Health facility **Other approved pharmacy products:** **Preferred generic drugs (Tier 1):** Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** Not covered; Member pays 100% of all charges

Transgender Services	
Medical and surgical services for gender reassignment. Surgical services may include initial mastectomy/breast reduction, hysterectomy, salpingo-oophorectomy, colpectomy, metoidioplasty, vanioplasty, colovaginoplasty, orchiectomy, penectomy, clitoroplasty and labiaplasty. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment
Exclusions: Gender reassignment services not specifically listed as covered, including breast augmentation/silicone injections of breast, blepharoplasty, facial feminization surgery, rhinoplasty, lip reduction/enhancement, face/forehead lift, chin/nose implants, trachea shave/reduction thyroid chondroplasty, laryngoplasty, liposuction, electrolysis/hair implant, jaw shortening/sculpting/facial bone reduction, collagen injections, removal of redundant skin and voice modification surgery, travel	

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays $15 Copayment **Outpatient Services:** After Deductible, Member pays $15 Copayment

are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits • Rehospitalization • Maintenance medications during an inpatient stay Transplant services require Preauthorization.	
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; transportation expenses except as covered as Ambulance Services	

Urgent Care	
Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Outside the Group Health Service Area, urgent care is covered at any medical facility. See the Definitions section for a definition of Urgent Condition.	**Network Emergency Department:** After Deductible, Member pays $100 Copayment **Network Urgent Care Center:** After Deductible, Member pays $15 Copayment **Network Provider's Office:** After Deductible, Member pays $15 Copayment **Outside the Group Health Service Area:** After Deductible, Member pays $150 Copayment

VII. General Exclusions

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

1. Services or supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the Summary Plan Description.

2. Follow-up services or complications related to non-Covered Services, except as required by federal law.

3. 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 family member, or self-care.

4. Convalescent Care.

5. 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, 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 receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.

   The Member and his/her agents must cooperate fully with Group Health in its efforts to enforce this exclusion. This cooperation shall include supplying Group Health with information about, or related to, the cause of injury or illness or the availability of other coverage. The Member and his/her agent shall permit Group Health, at Group Health'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 Group Health's right to enforce this exclusion. Failure to fully cooperate, including withholding information regarding the cause of injury or illness

or other coverage may result in denial of claims and the Member shall be responsible for reimbursing Group Health for expenses incurred and the value of the benefits provided by Group Health under this Plan for the care or treatment of the injury or illness sustained by the Member.

If this Plan is not subject to ERISA and reasonable collections costs (attorney fees and costs) have been incurred by an attorney for the injured person in connection with obtaining recovery under underinsured or uninsured motor coverage, under certain conditions Group Health will not enforce this exclusion until a reduction from benefits "available" to the Member is made by the amount of an equitable apportionment of such collection costs between Group Health and the injured person. This reduction is made only if each of the following conditions has been met: (i) Group Health receives a list of the fees and associated costs before settlement and (ii) the injured person's attorney's actions were reasonable and necessary to secure recovery.

6. 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.

7. Services provided by government agencies, except as required by federal or state law.

8. Services covered by the national health plan of any other country.

9. Experimental or investigational services.

   Group Health consults with Group Health'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:
      1) 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.
      2) The service is the subject of a current new drug or new device application on file with the FDA.
      3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
      4) 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.
      5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
      6) 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.
      7) 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. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
      1) The Member's medical records.
      2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
      3) Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service.
      4) 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.

5) The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury.
6) 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 Group Health denial of coverage can be submitted to the Member Appeal Department, or to Group Health's medical director at P.O. Box 34593, Seattle, WA 98124-1593.

10. Hypnotherapy and all services related to hypnotherapy.

11. Directed umbilical cord blood donations.

12. Prognostic (predictive) genetic testing and related services, unless specifically provided in the Benefits Details section. Testing for non-Members.

13. Autopsy and associated expenses.

VIII. Grievances

Grievance means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. The grievance process is outlined as follows:

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 Customer Service at 206-901-4636 or toll-free 1-888-901-4636. 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 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 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 Customer Service.

IX. Appeals

The appeals process is available for a Member to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan. Group Health will comply with any new requirements as necessary under federal laws and regulations. The most current information about your appeals process is available by contacting Group Health's Member Appeal Department at the address or telephone number below.

1. Internal Review

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. Group Health will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to Group Health's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, toll free 1-866-458-5479.

Group Health will then notify the Member of its determination or need for an extension of time within 15 days of receiving the request for appeal and if more time is required, will notify the Member in writing to extend to 30 days. Under no circumstances will the review timeframe exceed 30 days without the Member's written permission.

For appeals involving experimental or investigational services Group Health will make a decision and communicate the decision to the Member in writing within 20 working days of receipt of the appeal.

Expedited/Urgent Internal Review

There is an expedited/urgent appeals process in place for cases which meet criteria or where the Member's provider believes that the standard 15 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. Group Health will accept a treating provider's determination that an appeal should be expedited/urgent. The Member can request an expedited/urgent appeal in writing to the above address, or by calling Group Health's Member Appeals Department toll free 1-866-458-5479. The Member's request for an expedited/urgent appeal will be processed as such if the definition above is met and a decision issued and communicated verbally no later than 72 hours after receipt of the request. If additional information is needed, Group Health will inform the Member and allow up to 48 hours for a response.

If the Member is currently receiving care that is the subject of the appeal, the health plan will continue coverage pending the outcome of the internal appeal.

The Member may also request an external review at the same time as the internal appeals process if it is an urgent care situation or the Member is in an ongoing course of treatment.

2. External Review

If the Member is not satisfied with the decision regarding medical necessity, medical appropriateness, health care setting, level of care, or if the requested service is not efficacious or otherwise unjustified under evidence-based medical criteria, the Member may request a second level review by an external independent review organization not legally affiliated or controlled by Group Health or the employer's health plan. Group Health will notify the Member of the name of the external independent review organization and its contact information. The external independent review organization will accept additional written information for up to five business days after it receives the assignment for the appeal. The external independent review will be conducted at no cost to the Member. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health.

A request for a review by an independent review organization must be made within 180 days after the date of the initial appeal decision notice.

X. Claims

Claims for benefits may be made before or after services are obtained. Group Health recommends that the provider requests Preauthorization. In most instances, contracted providers submit claims directly to Group Health. If your provider does not submit a claim to make a claim for benefits, a Member must contact 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, the Member must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either (1) contact Customer Service to make a claim or (2) pay the bill and submit a claim for reimbursement of Covered Services to Group Health, 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 1 year from the date of service.

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

- Pre-service claims – within 15 days.
- Claims involving urgently needed care – within 72 hours.
- Concurrent care claims – within 24 hours.
- Post-service claims – within 30 days.

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

XI. 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. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

If the Member is covered by more than one health benefit plan, and the Member does not know which is the primary plan, the Member or the Member's provider should contact any one of the health plans to verify which plan is primary. The health plan the Member contacts is responsible for working with the other plan to determine which is primary and will let the Member know within 30 calendar days.

All health plans have timely claim filing requirements. If the Member or the Member's provider fails to submit the Member's claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If the Member experiences delays in the processing of the claim by the primary health plan, the Member or the Member's provider will need to submit the claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

A. Definitions.

1. 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.

    a. 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.

    b. 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 a. or b. 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.

2. 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.

3. 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 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 by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period.

4. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, 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:

   a. 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.

   b. 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.

   c. 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.

   d. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.

5. 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.

6. 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.

B. 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:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

2. 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 employee. 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.

3. 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.

4. Each plan determines its order of benefits using the first of the following rules that apply:

   a. 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.

   b. 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:
      1) 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.
      2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. 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;
         ii. 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;
         iii. 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;

iv. 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

v. 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.

3) 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.

c. 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.

d. 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, employee or retiree or covering the Member as a Dependent of an employee, member, employee 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 a. can determine the order of benefits.

e. Longer or shorter length of coverage. The plan that covered the Member as an employee, member, employee or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.

f. 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.

C. Effect on the Benefits of this Plan.

When this plan is secondary, it 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 expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Member be responsible for a deductible amount greater than the highest of the two deductibles.

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

E. Facility of Payment.

If payments that should have been made under this plan are made by another plan, Group Health 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, Group Health is fully discharged from liability under this plan.

F. Right of Recovery.
Group Health 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. Group Health 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.

G. Effect of Medicare.
Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status, and will be adjudicated by Group Health as set forth in this section. Group Health will pay primary to Medicare when required by federal law. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

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

XII. Subrogation and Reimbursement Rights

The benefits under this Plan will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Plan. If the Plan provides for the treatment of the injury or illness, the Plan will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse the Plan for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section more fully describes the Plan's subrogation and reimbursement rights.

"Injured Person" under this section means a Member covered by the Plan who sustains an injury or illness 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, "the Plan's Medical Expenses" means the expenses incurred and the value of the benefits provided by the Plan for arranging the care or treatment of the injury or illness 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, the Plan shall have the right to recover the Plan'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." The Plan shall be subrogated to and may enforce all rights of the Injured Person to the full extent of the Plan's Medical Expenses.

The Plan'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.

If the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury *or* illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, the Plan's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with the Plan in its efforts to collect the Plan's Medical Expenses. This cooperation includes, but is not limited to, supplying the Plan with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim and informing the Plan of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit the Plan, at the Plan'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 the Plan to initiate its own direct action for reimbursement or subrogation.

The Injured Person and his/her agents shall do nothing to prejudice the Plan's subrogation and reimbursement rights. The Injured Person shall promptly notify the Plan of any tentative settlement with a third party and shall not settle a claim without protecting the Plan's interest. If the Injured Person fails to cooperate fully with the Plan in recovery of the Plan's Medical Expenses, the Injured Person shall be responsible for directly reimbursing the Plan for 100% of the Plan'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 a separate identifiable account until the Plan's subrogation and reimbursement rights are fully determined and that the Plan has an equitable lien over such monies to the full extent of the Plan's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of the Plan's Medical Expenses.

XIII. Definitions

Allowance	The maximum amount payable by the Plan for certain Covered Services.
Allowed Amount	A term used to define the level of benefits which are payable by Group Health when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount 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. Members shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Plan.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under Group Health's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of an employee's family who meets all applicable eligibility requirements, is enrolled hereunder.

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, or if the Member is pregnant, the health of her unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Family Unit	An employee and all his/her Dependents.
Group Health-designated Specialist	A specialist specifically identified by Group Health.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by Group Health's medical director 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 Group Health'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 Group Health's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Member	Any enrolled employee or Dependent.
Network Facility	A facility (hospital, medical center or health care center) owned, operated or otherwise designated by Group Health, or with whom Group Health has contracted to provide health care services to Members.
Network Personal Physician	A provider who is employed by or contracted with Group Health 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 Plan which a Member can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Group Health, and any other health care professional or provider with whom Group Health has contracted to provide health care services to Members, 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.
Out-of-pocket Expenses	Those Cost Shares paid by the employee 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 employee and his/her Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in the Benefits Details section.
Plan	The City of Seattle Group Health Plan.
Plan Administrator	City of Seattle.
Plan Coinsurance	The percentage amount the Member is required to pay for Covered Services received.
Preauthorization	An approval by Group Health that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the Plan. Members who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
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 Group Health.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to

	require medical treatment within 24 hours of its onset.

XIV. Plan Administration and Legal Rights

About your summary plan description
The information contained in this booklet, together with your certificates of coverage, certificates of insurance, open enrollment materials, and other explanatory materials constitutes your summary plan description. The summary plan description provides highlights of the health benefit plan, (the "Plan"), by City of Seattle —the employer and plan sponsor.
The summary plan description does not create a contract of employment.

Amendment or termination of plan
City of Seattle, the Plan sponsor, reserves the right to change, suspend or discontinue the Plan in whole or in part at any time, and doesn't promise to continue any specific level of benefits during or after employment, including during retirement.

Authority of plan administrator
City of Seattle is the plan administrator of the Plan. City of Seattle, as plan administrator, has the sole discretionary authority to interpret the Plan and determine eligibility with respect to non-insured benefits, determine the amount of non-insured benefits payable under the Plan, make any related findings of fact, and resolve any ambiguities that may exist between the summary plan description and the plan documents. All such decisions by the plan administrator will be final and binding on participants and beneficiaries to the fullest extent permitted by law.

Rights of recovery
Benefits under the medical plan are available to cover services or supplies necessary due to illness or injury for which a third party is liable because of negligent or wrongful acts or omissions, subject to the exclusions, limitations and conditions of the plans, including rights related to reimbursement and subrogation.

Reimbursement
If you receive payment as compensation for any condition or injury caused by a third party, the plan has the right to seek reimbursement for any benefits the plan may have paid or provided for that condition or injury. In some cases, the plan may reserve the right to recover the actual amount of reimbursement received; in others, the reasonable value of the reimbursement. (Check with the individual claim administrators for details.)

Notice of privacy practices
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Review it carefully.

The City of Seattle Group Health Plan (the "Plan") is an employee benefits plan that provides welfare (non-pension) benefits to eligible staff members and their spouses, domestic partners and dependents. The Plan is a "group health plan" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As such, it is a "covered entity" as defined by HIPAA, subject to the requirements of HIPAA with respect to the use and disclosure of your medical information.

City of Seattle is the "plan sponsor" of the Plan. The Plan is required by law to protect the privacy of your personal information and provide you with this Notice which explains its responsibilities and privacy practices regarding your personal information. The Plan is also required to abide by the terms of this Notice. This Notice is designed to inform you of the Plan's privacy practices in accordance with HIPAA.

In this Notice, the term "personal information" refers to any medical or financial information that can reasonably be used to identify you and relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care. Personal information may include your name, Social Security number, address, telephone number, employment, medical history, health records, claims information, or credit card number.

Use and disclosure of your personal information
The following summarizes the circumstances under which and purposes for which the Plan may use or disclose your personal information:

- **For treatment.** The Plan may use or disclose your personal information for the provision, coordination or management of health care or related services. For example, if you receive your medical care at Group Health, information you submit through your Health Profile may be included in your Group Health medical record.
- **For payment.** The Plan may use or disclose your personal information for payment purposes. Payment includes activities undertaken by the Plan to obtain premiums, to determine and fulfill its responsibilities for coverage and the provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. For example, payment may include determining benefit eligibility and coordinating benefits with other health plans, reviewing services for medical necessity, paying a claim, performing utilization review, obtaining premiums, subrogating a claim, and collection activities.
- **For health care operations.** The Plan may use or disclose your personal information to carry out its own health care operations, including general administration of the plan. For example, the Plan may use your personal information to review and improve the care you receive, to provide disease and case management, for health plan underwriting, to administer and review a health plan, to conduct medical reviews, and to provide customer service. Health care operations may also include determining coverage policies, business planning, arranging for legal and auditing services, obtaining accreditations and licenses, referrals to a disease management program, suggesting treatment alternatives, projecting future benefit costs or auditing the accuracy of its claims processing functions.
- **To business associates.** The Plan may disclose your personal information to the Plan's business associates. Business associates are persons who, on behalf of the Plan, perform or assist in the performance of a function or activity involving the use or disclosure of personal information described in this Notice. For example, the Plan may contract with a Business Associate to provide the Plan with legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. The Plan's business associates must agree in writing to safeguard the confidentiality of your personal information.
- **In legal proceedings.** The Plan may disclose your personal information in response to a court order and in certain cases, in response to a subpoena, discovery request, or other lawful process. Also for law enforcement purposes when required by federal state or local law enforcement.
- **For law enforcement.** The Plan may disclose your personal information to law enforcement officials in limited circumstances for law enforcement purposes. For example, disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- **As required by law.** The Plan may use or disclose your personal information when it is required to do so by law.
- **For treatment alternatives or distribution of health-related benefits & services.** The Plan may use or disclose your personal information to remind you about preventive health services or to let you know about treatment alternatives, providers, settings of care, or health and wellness products or services that are available for you as a health plan participant.
- **Disclosures to the Plan Sponsor.** The Plan may disclose your health information to City of Seattle, the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

  The Plan may also disclose "summary health information", if requested by the Plan Sponsor for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. Summary health information is information (which may be personal information) from which personal identifiers (except zip code) have been removed, and which summarizes claims history, claims expense or types of claims experienced by individuals for whom the Plan sponsor has provided health benefits under the Plan.

  The Plan may also disclose to the Plan Sponsor whether an individual is participating in the Plan.

  The Plan **will not** disclose your personal information to the Plan Sponsor for purposes of employment-related decisions or actions, or in connection with any other benefit plan of the Plan Sponsor.

- **To conduct health oversight activities.** The Plan must agree to oversight reviews by federal and state agencies. These agencies may, by law conduct audits, perform inspections and investigations, license health care providers, health plans and health care facilities, and enforce federal and state regulations
- **With an authorized public health authority or their agent** in the event of a serious threat to the health and safety of the public.
- **For specified government functions.** With government benefit programs, like **Medicare** and **Medicaid**, the Plan may use or disclose your personal information in order to review your eligibility and enrollment in these programs. With **armed forces personnel**, the Plan may use or disclose your personal information for military activities and to authorized **federal officials** for national security activities and intelligence purposes.
- **For workers' compensation.** The Plan may use or disclose your personal information to the workers' compensation program which provides benefits to you if you have a work-related injury or illness.
- **For research.** The Plan may use or disclose your personal information for the Plan's or another organization's research purposes provided that certain steps are taken to protect your privacy.
- **For fundraising.** The Plan may disclose your personal information to the Group Health Foundation, a nonprofit charitable organization supporting Group Health and the community, to raise funds for the Foundation.
- **To "de-identify" information.** The Plan may use or disclose your personal information in order to de-identify it by removing information that could be used to identify you.
- **In case of threat to health or safety.** The Plan may use or disclose your personal information in order to avoid a serious threat to the health or safety of yourself and others.

Other uses of your medical information
Except in the situations described above, the Plan will use and share your personal information only with your written permission or authorization.

Changes to privacy practices
You have rights regarding personal information that the Plan maintains about you. You may get more information about exercising any of these rights by calling the Privacy Office at (206) 684-7832.

- **Request restrictions:** You may request that the Plan limit the way it uses or shares your personal information outside of the Plan.
- **Confidential communication:** You may ask that the Plan contact you at a different address or phone number. The Plan will usually be able to accommodate your request. Please make your request in writing.
- **Inspect and copy:** You may request a copy of your personal information maintained by or for the Plan in a designated record set. The Plan may maintain the following records in a designated record set: enrollment, payment, claims adjudication, care management and other records that are used by the Plan, in whole or in part, to make decisions about you. Such requests must be made in writing. The Plan may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations the Plan may deny your request and tell you why your request has been denied. You have the right to ask for a review of the Plan's denial.
- **Amendments:** You may ask the Plan to correct or amend your personal information maintained by the Plan. Your request for a change to your personal information must be in writing and give a reason for your request. The Plan may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with health plan information.
- **Accounting of disclosures:** You may seek an accounting of certain disclosures by asking for a list of the times the Plan has shared your personal information. Your request must be in writing and give the specific information the Plan needs in order to respond to your request.
- **Notice of privacy practices:** The Plan must send a Notice of privacy practices that describes the use and disclosures of personal information by the health plan to the subscriber. You may ask general questions about this Notice by calling the Privacy Office at (206) 684-7832.

Questions and complaints
If you have questions about this Notice or want to file a complaint about the Plan's privacy practices, including the process for breach notification, write to City of Seattle Personnel Department, Benefits Unit, 700 5th Avenue, Suite 5500, Seattle, WA 98104. For more information on how to file a written complaint, call the Privacy Office at (206) 684-7832. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you if you file a complaint about its privacy practices with the Plan or with the Department of Health and Human Services.

Changes to privacy practices
The Plan may change the terms of this Notice at any time. Any such changes will be effective for all personal information maintained by the Plan. If the Plan changes any of the privacy practices described in this Notice, the Plan will post the revised notice on http://www.seattle.gov/personnel/benefits/library/notices.asp. The Plan may also give you additional information about its privacy practices in other notices it provides. This Notice is effective as of April 14, 2003.

Foreign language assistance
Contact the appropriate claim administrator or the plan administrator if you would like translation services to understand your benefits.

Notice On The Women's Health And Cancer Rights Act Of 1998
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided by in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided by the Plan. If you would like more information on these benefits or your rights under this federal law, please contact the Plan Administrator, Renee Freiboth, at (206) 684-7833.

Notice Of Rights Under The Newborns' And Mothers' Health Protection Act Of 1996
Under federal law, group health plans and benefits such as the Plan's health benefits generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, group health plans may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may under federal law be required to obtain preauthorization before going into a hospital for these services or any other type of services under group health plan coverage.

XV. Plan Identification Data

Plan name:	The City of Seattle's Deductible Group Health Plan
Employers:	City of Seattle 700 5th Avenue, Suite 5500 Seattle, WA 98124-4028
Plan number:	0961000/4961000
Type of plan:	Self funded health benefits plan
Plan year:	January 1, 2015 - December 31, 2015
Plan Sponsor:	City of Seattle
Plan Administrator:	City of Seattle 700 5th Avenue, Suite 5500 Seattle, WA 98124-4028 Plan Contact: Benefits Manager (206) 684-7833
Employer identification number (EIN):	2909
Agent for legal process:	City of Seattle Attorney 600 4th Avenue, 4th Floor Seattle, WA 98104 Service may also be made on the Plan Administrator
Source of contributions and funding:	City of Seattle pays for the full cost of medical coverage. City of Seattle is a party to group insurance contracts or vendor agreements for the provision of other benefits described in this SPD.
Type of administration:	Administered by plan sponsor in accordance with summary plan descriptions, group insurance contracts, and plan documents
Description of collective bargaining agreement:	For certain staff, this plan is maintained according to one or more collective bargaining agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator and is available for examination by participants and beneficiaries

Benefit and Claims Administrators

Benefit	Administrator
Health Benefits (including pharmacy and optical coverage)	Group Health Cooperative P.O. Box 34585 Seattle, WA 98124-1585 206-901-4636 or 1-888-901-4636 www.ghc.org