Group Health Options, Inc.
Contracts and Coverage
PO BOX 34589
Seattle, WA 98124-1589

Enclosed is the 2011 Group Health Options, Inc. medical coverage agreement.

Please have the group's representative sign the signature page and return to the Contracts and Coverage department by mail or email to:

Mail:
Group Health Contracts Department
PO Box 34589
Seattle, WA 98124-1589

Email:
contractscoveragepro@ghc.org
Please use your group number as the subject.

Benefit or contract provisions that you or Group Health might have requested or negotiated during the renewal process are included in the enclosed medical coverage agreement. The Premium schedule, which is part of the medical coverage agreement, confirms the premiums specified in a previous letter, which the group has accepted.

If you have any questions about this information or your new contract, please call your Marketing account executive:

Seattle	(206) 448-4140 or toll free in WA 1-800-542-6312
Tacoma	(253) 383-6226 or toll free in WA 1-800-854-5322
Eastern WA/NorthID	(509) 459-9100 or toll free in WA 1-800-497-2210
Central WA	(509) 783-3484 or toll free in WA 1-800-458-5450

We appreciate your business.

Sincerely,

Contract Administration

Group Medical Coverage Agreement

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

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

- Standard Provisions
- Attached Benefit Booklet
- Signed Group application
- Premium Schedule

Group Health Cooperative

Signed: 

Title: President and Chief Executive Officer

City of Spokane, 4983000

Signed:

Title:

This Agreement will continue in effect until terminated or renewed as herein provided for and is effective January 1, ***2011***.

PA-113311
1704EID2011

Group Medical Coverage Agreement
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Standard Provisions

1. GHC agrees to provide benefits as set forth in the attached Benefit Booklet to enrollees of the Group.

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

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

3. **Dissemination of Information.** Unless the Group has accepted responsibility to do so, GHC will disseminate information describing benefits set forth in the Benefit Booklet attached to this Agreement.

4. **Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under this Agreement.

5. **Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of this Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

6. **Modification of Agreement.** Except as required by federal and Washington State law, this Agreement may not be modified without agreement between both parties.

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

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

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

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

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

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

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

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

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

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

12. **HIPAA.**

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

    Transactions Accepted. GHC will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. ***The Group shall ensure that all Standard Transactions transmitted to GHC by the Group or the Group's business associates are in compliance with HIPAA standards for electronic transactions. The Group shall indemnify GHC for any breach of this section by the Group.***

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

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

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

    c. **Underwriting Guidelines.** GHC may terminate this Agreement in the event the Group no longer meets underwriting guidelines established by GHC that were in effect at the time the Group was accepted.

d. Federal or State Law. GHC may terminate this Agreement in the event there is a change in federal or state law that no longer permits the continued offering of the coverage described in this Agreement.

14. Withdrawal or Cessation of Services.

a. GHC may determine to withdraw from a Service Area or from a segment of its Service Area after GHC has demonstrated to the Washington State Office of the Insurance Commissioner that GHC's clinical, financial or administrative capacity to service the covered Members would be exceeded.

b. GHC may determine to cease to offer the Group's current plan and replace the plan with another plan offered to all covered Members within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. GHC may also allow unrestricted conversion to a fully comparable GHC product.

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

Dear Group Health Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2011 Group Health Benefit Booklet (Certificate of Coverage). It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Cooperative. Sections of this document may be ***bolded and italicized,*** which identifies changes that Group Health has made to the plan. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health for your healthcare coverage. If you are eligible for Medicare, please read Section IV.J. as it may affect your prescription drug coverage.

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

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

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

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

Very truly yours,

Scott Armstrong
President

PA-1133a11, CA-1395a11 ,CA-111011,CA-136011,CA-182411,CA-11711,CA-138511,CA-334611,CA-3768
CA-3712
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Benefit Booklet
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Group Health Cooperative believes 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 GHC Customer Service at (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Section I. Introduction

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

Read This Benefit Booklet Carefully

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

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

A. Accessing Care

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

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

Members may refer to Sections IV.A. and IV.C. for more information about inpatient admissions.

Primary Care. GHC recommends that Members select a GHC Personal Physician when enrolling under the Agreement. One Personal Physician may be selected for an entire family, or a different Personal Physician may be selected for each family member.

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

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

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

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

GHC-Designated Self-Referral Specialist. Members may make appointments directly with GHC-Designated Self-Referral Specialists at Group Health-owned or -operated medical centers without a Referral from their

Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy*, smoking cessation, speech/language and learning services* and urology.

* Medicare patients need prior authorization for these specialists.

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

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

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

In the GHC Service Area, urgent care is covered at GHC medical centers, GHC urgent care clinics or GHC Provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider. Care received at urgent care facilities other than those listed above is only covered for emergency services, subject to the applicable Emergency Cost Share. Members may refer to Section IV. for more information about coverage of urgent care services.

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

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

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

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

Unusual Circumstances. If the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of facilities, military action, civil disorder, labor disputes or similar causes, GHC shall provide or arrange for services that, in the reasonable opinion of GHC's Medical Director, or his/her designee, are emergent or urgently needed. In regard to nonurgent and routine services, GHC shall make a good faith effort to provide services through its then-available facilities and personnel. GHC

shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected. In no case shall GHC have any liability or obligation on account of delay or failure to provide or arrange such services.

B. Cost Shares

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

1. **Copayments**. Members shall be required to pay Copayments at the time of service as set forth in the Allowances Schedule. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service.

2. **Coinsurance.** Members shall be required to pay coinsurance for certain Covered Services as set forth in the Allowances Schedule.

3. **Out-of-Pocket Limit.** Total Out-of-Pocket Expenses incurred during the same calendar year shall not exceed the Out-of-Pocket Limit set forth in the Allowances Schedule. Out-of-Pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in the Allowances Schedule.

C. Subscriber's Liability

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

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

D. Claims

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

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

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

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

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

Section II. Allowances Schedule

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

"Welcome" Outpatient Services Waiver

Not applicable.

Annual Deductible

No annual Deductible.

Plan Coinsurance

No Plan Coinsurance.

Lifetime Maximum

No Lifetime Maximum ***on covered Essential Health Benefits.***

Hospital Services

- Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)

  Covered in full.

- Covered outpatient hospital surgery (including ambulatory surgical centers)

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

Outpatient Services

- Covered outpatient medical and surgical services

  Covered subject to the lesser of GHC's charge or a $5 outpatient services Copayment per Member per visit.

- Allergy testing

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

- Oncology (radiation therapy, chemotherapy)

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

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

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHC drug formulary

  Covered subject to the lesser of GHC's charge or a $10 Copayment for generic drugs or a $30 Copayment for brand name drugs.

- Over-the-counter drugs and medicines

  Not covered.

- Injectables

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

- Mail order drugs and medicines ***dispensed through the GHC-designated mail order service***

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

Out-of-Pocket Limit

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

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

Acupuncture

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

Ambulance Services

- Emergency ground/air transport

  Covered in full.

- Non-emergent ground/air interfacility transfer

  Covered in full for GHC-initiated transfers, including hospital-to-hospital ground transfers.

Chemical Dependency

- Inpatient services (including Residential Treatment services)

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

- Outpatient services

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

Acute detoxification covered as any other medical service.

Dental Services (including accidental injury to natural teeth)

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

Devices, Equipment and Supplies (for home use)

Covered in full for:

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

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

Diabetic Supplies

Insulin, needles, syringes and lancets – see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies.

Diagnostic Laboratory and Radiology Services

Covered in full.

Emergency Services

- At a GHC Facility

  Covered subject to the lesser of GHC's charge or a $50 Copayment per Member per Emergency visit. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

- At a non-GHC Facility

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

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

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

- Hearing aids, including hearing aid examinations

  Not covered.

Home Health Services

Covered in full. No visit limit.

Hospice Services

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

Infertility Services (including sterility)

- General diagnostic services

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

- Specific diagnostic services, treatment and outpatient prescription drugs

  Covered at 50% (Member's Cost Share will not exceed GHC's charge).

Manipulative Therapy

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

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

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

- Prenatal and postpartum care

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

- Pregnancy termination

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

Mental Health Services

- Inpatient services

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

- Outpatient services

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

Naturopathy

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

Nutritional Services

- Phenylketonuria (PKU) supplements

  Covered in full.

- Enteral therapy (formula)

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

- Parenteral therapy (total parenteral nutrition)

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

Obesity Related Services

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

On the Job Injuries or Illnesses

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

Optical Services

- Routine eye examinations

  Covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the lesser of GHC's charge or the applicable outpatient services Copayment as often as Medically Necessary.

- Lenses, including contact lenses, and frames

  Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting - Covered up to $200 per twenty-four (24) month period per Member. The benefit period begins on the date services are first obtained and continues for twenty-four (24) months.

- Contact lenses for eye pathology, including following cataract surgery - Covered in full.

Organ Transplants

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

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

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

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

- Cosmetic surgery, including complications resulting from cosmetic surgery

  Not covered.

Podiatric Services

- Medically Necessary foot care

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

- Foot care (routine)

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

Pre-Existing Condition

Covered with no wait.

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

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

Rehabilitation Services

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

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

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

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

Sexual Dysfunction Services

Not covered.

Skilled Nursing Facility (SNF)

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

Sterilization (vasectomy, tubal ligation)

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

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

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

- Lifetime benefit maximum

  Covered up to $5,000 per Member.

Tobacco Cessation

- Individual/group sessions ***received through the GHC-designated tobacco cessation program***

  Covered in full.

- Approved pharmacy products

  Covered in full when prescribed as part of the GHC-designated tobacco cessation program and dispensed through the GHC-***designated*** mail order service.

Section III. Eligibility, Enrollment and Termination

A. Eligibility

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

1. **Subscribers.** Bona fide employees who have been continuously employed on a regularly scheduled basis of not less than eighty (80) hours in a calendar month shall be eligible for enrollment.

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

   a. The Subscriber's legal spouse**,** including state-registered domestic partners as required by Washington state law;

   b. Dependent children who are under the age of twenty-six (26).

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

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

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

B. Enrollment

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

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

   a. Newly Eligible Persons. Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible.

   b. New Dependents. A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within thirty-one (31) days after the dependency occurs.

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

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

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

c. Open Enrollment. GHC will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during a limited period of time specified by the Group and GHC.

d. Special Enrollment.

1) GHC will allow special enrollment for persons:
   a) who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
      - cessation of employer contributions,
      - exhaustion of COBRA continuation coverage,
      - loss of eligibility, except for loss of eligibility for cause; or
   b) who have had such other coverage exhausted because such person reached a Lifetime Maximum limit.

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

2) GHC will allow special enrollment for individuals who are eligible to be a Subscriber, his/her spouse and his/her Dependents in the event one of the following occurs:
   - marriage. Application for coverage under the Agreement must be made within thirty-one (31) days of the date of marriage.
   - birth. Application for coverage under the Agreement for the Subscriber and Dependents other than the newborn child must be made within sixty (60) days of the date of birth.
   - adoption or placement for adoption. Application for coverage under the Agreement for the Subscriber and Dependents other than the adopted child must be made within sixty (60) days of the adoption or placement for adoption.
   - eligibility for medical assistance: provided such person is otherwise eligible for coverage under this Agreement, when approved and requested in advance by the Department of Social and Health Services (DSHS).
   - applicable federal or state law or regulation otherwise provides for special enrollment.

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

C. Effective Date of Enrollment

1. Provided eligibility criteria are met and applications for enrollment are made as set forth in Sections III.A. and III.B. above, enrollment will be effective as follows:

- Enrollment for a newly eligible Subscriber and listed Dependents is effective on the first (1st) of the month following thirty (30) days of continuous employment, provided the Subscriber's application has been submitted to and approved by GHC.
- Enrollment for employees returning from a lay-off is effective on the first (1st) of the month following return to work if rehired within thirty six (36) months.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first (1st) of the month following the date eligibility requirements are met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes total or partial financial support of the child.

2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above. If a Member is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Member to a GHC Facility. The Member will be transferred when a GHC Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. Eligibility for Medicare

An individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits. Medicare Secondary Payer regulations and guidelines will determine primary/secondary payer status for individuals covered by Medicare.

Actively Employed Members and Spouses. The Group is responsible for providing the Member with necessary information regarding ***Tax Equity and Fiscal Responsibility Act of 1982*** (TEFRA) eligibility and the selection process***, if applicable. A Member who is eligible for Medicare has the option of maintaining both Medicare Parts A and B while continuing coverage under this Agreement. Coverage between this Agreement and Medicare will be coordinated as outlined in Section VII.A***.

Not Actively Employed **Members.** If a Member who is not actively employed is eligible for Medicare ***based on age***, he/she must enroll in and maintain both Medicare Parts A and B coverage and enroll in the GHC Medicare Advantage Plan ***if available***. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under this Agreement.

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

E. Termination of Coverage

1. **Termination of Specific Members.** Individual Member coverage may be terminated for any of the following reasons:

   a. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in Section III., and is not enrolled for continuation coverage as described in Section III.G. below, coverage under the Agreement will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.

   b. **For Cause.** Coverage of a Member may be terminated upon ten (10) working days written notice for:

      i. Material misrepresentation, fraud or omission of information in order to obtain coverage.
      ii. Permitting the use of a GHC identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

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

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

Individual Member coverage may be retroactively terminated upon thirty (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. Notwithstanding the foregoing, GHC reserves the right to retroactively terminate coverage for nonpayment of premiums or contributions by the Group, as described under subsection c. above.

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

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

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

F. Services After Termination of Agreement

1. Members Hospitalized on the Date of Termination. A Member who is receiving Covered Services as a registered bed patient in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

- According to GHC clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available under the Agreement for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under an agreement with another carrier that would provide benefits for the hospitalization if the Agreement did not exist.

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

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

G. Continuation of Coverage Options

1. Continuation Option. A Member no longer eligible for coverage under the Agreement (except in the event of termination for cause, as set forth in Section III.E.) may continue coverage for a period of up to three (3) months subject to notification to and self-payment of premiums to the Group. This provision will not apply if the Member is eligible for the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This continuation option is not available if the Group no longer has active employees or otherwise terminates.

2. **Leave of Absence.** While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered under the Agreement provided:

   - They remain eligible for coverage, as set forth in Section III.A.,
   - Such leave is in compliance with the Group's established leave of absence policy that is consistently applied to all employees,
   - The Group's leave of absence policy is in compliance with the Family and Medical Leave Act when applicable, and
   - The Group continues to remit premiums for the Subscriber and Dependents to GHC.

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, a Subscriber may continue uninterrupted coverage under the Agreement through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for six (6) months after the cessation of work.

   If the Agreement is no longer available, the Subscriber shall have the opportunity to apply for an individual GHC Group Conversion Plan or, if applicable, continuation coverage (see subsection 4. below), or an Individual and Family Medical Coverage Agreement at the duly approved rates.

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

4. **Continuation Coverage Under Federal Law.** This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and only applies to grant continuation of coverage rights to the extent required by federal law.

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

   Continuation coverage under COBRA will terminate when a Member becomes covered by Medicare or obtains other group coverage, and as set forth under Section III.E.1.b. and c.

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

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

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

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

Section IV. Schedule of Benefits

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

A. Hospital Care

Hospital coverage is limited to the following services:

1. Room and board, including private room when prescribed, and general nursing services.

2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).

3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Coverage must be authorized in advance by GHC as appropriate and Medically Necessary. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.

4. Drugs and medications administered during confinement.

5. Special duty nursing, when prescribed as Medically Necessary.

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

B. Medical and Surgical Care

Medical and surgical coverage is limited to the following:

1. Surgical services.

2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services.

3. Family planning counseling services.

4. Hearing examinations to determine hearing loss.

5. Blood and blood derivatives and their administration.

6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHC ***and the Patient Protection and Affordable Care Act of 2010***. Preventive care includes: routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHC, and immunizations and vaccinations listed as covered in the GHC drug formulary

(approved drug list). A fee may be charged for health education programs. The well care schedule is available in GHC clinics, by accessing GHC's website at www.ghc.org, or upon request.

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

7. Radiation therapy services.

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

9. Medical implants.

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

10. Respiratory therapy.

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

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

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

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

13. Optical services.

    Routine eye examinations and refractions received at a GHC Facility once every twelve (12) months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered as often as necessary upon recommendation of a GHC Provider.

    Contact lenses for eye pathology, including contact lens exam and fitting, are covered subject to the applicable Cost Share. When dispensed through GHC Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery performed by a GHC Provider, provided the Member has been continuously covered by GHC since such surgery.

    Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twelve (12) month period and only when needed due to a change in the Member's Medical Condition. Replacement for loss or breakage is subject to the Lenses and Frames benefit Allowance.

    Lenses and Frames

    Benefits purchased at a Group Health-owned or contracted optical hardware provider may be used toward the following in any combination, over the benefit period, until the benefit maximum is exhausted:

    - Eyeglass frames
    - Eyeglass lenses (any type) including tinting and coating
    - Corrective industrial (safety) lenses

- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity
- Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures.

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

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

    Hospitalization and delivery, including home births for low risk pregnancies.

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

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

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

15. Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Covered Services must be directly associated with, and occur at the time of, the transplant. Services are limited to the following:

    a. Evaluation testing to determine recipient candidacy,
    b. Matching tests,
    c. Inpatient and outpatient medical expenses listed below for transplantation procedures:

        - Hospital charges,
        - Procurement center fees,
        - Professional fees,
        - Travel costs for a surgical team, and
        - Excision fees

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

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

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

16. Manipulative therapy.

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

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

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

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

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

18. Diabetic training and education.

19. Detoxification services for alcoholism and drug abuse.

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

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

20. Circumcision.

21. Nutritional counseling provided by GHC staff.

22. Sterilization procedures.

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

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

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

Excluded: herbal supplements, preventive care visits ***for acupuncture*** and any services not within the scope of ***the practitioner's*** licensure.

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

26. Injections administered by a professional in a clinical setting.

27. Infertility services when authorized as medically appropriate by GHC's Medical Director, or his/her designee, and in accordance with criteria established by GHC, limited to general diagnostic services and specific diagnostic services, medical and surgical treatment and drug therapy.

    Excluded: all forms of artificial intervention, including insemination, GIFT, ZIFT, in-vitro fertilization and diagnosis and treatment of sexual dysfunction.

C. Chemical Dependency Treatment.

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

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

Chemical dependency treatment services are covered as set forth in the Allowances Schedule at a GHC Facility or GHC-approved treatment program.

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

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

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

1. Correction of a congenital disease or congenital anomaly, as determined by a GHC Provider. A congenital anomaly will be considered to exist if the Member's appearance resulting from such condition is not within the range of normal human variation.

2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHC which has produced a major effect on the Member's appearance, when in the opinion of a GHC Provider, such services can reasonably be expected to correct the condition.

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

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

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

Excluded: complications of noncovered surgical services.

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

1. The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.

2. The Member requires intermittent skilled home health care services, as described below.

3. A GHC Provider has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

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

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

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

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

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

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

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

a. Home Services

i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
ii. Continuous care services in the Member's home when prescribed by a GHC Provider, as set forth in this paragraph. “Continuous care” means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Member at home. Continuous care may be provided for pain or symptom management by a Registered

Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a GHC Provider determines that the Member would otherwise require hospitalization in an acute care facility.

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

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

c. Other covered hospice services may include the following:

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

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

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

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

G. Rehabilitation Services.

1. Rehabilitation services are covered as set forth in this section, limited to the following: physical therapy; occupational therapy; ***massage therapy*** and speech therapy to restore function following illness, injury or surgery. Services are subject to all terms, conditions and limitations of the Agreement, including the following:

a. All services must be provided at a GHC or GHC-approved rehabilitation facility and ***require a prescription from a GHC physician and*** must be provided by a GHC-approved rehabilitation team that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.

b. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when GHC's Medical Director, or his/her designee, determines that significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.

c. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

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

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

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

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

H. Devices, Equipment and Supplies.

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

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

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

2. **Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.

3. **Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member’s home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHC, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.

4. **Prosthetic Devices.** Prosthetic devices are items which replace all or part of an external body part, or function thereof.

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

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

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

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

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

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

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

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

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

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

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and

injections for anticipated illness while traveling; vitamins, including Legend (prescription) vitamins; and any other drugs, medicines and injections not listed as covered in the GHC drug formulary unless approved in advance by GHC as Medically Necessary.

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

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

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered under the Agreement and what coverage limitations are in the Agreement. Members who would like more information about the drug coverage policies under the Agreement, or have a question or concern about their pharmacy benefit, may contact GHC at (206) 901-4636 or (888) 901-4636.

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

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

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

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

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

   Services provided under involuntary commitment statutes shall be covered at facilities approved by GHC. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary by GHC's Medical Director, or his/her designee.

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

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

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

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

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

L. Emergency/Urgent Care.

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

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

1. At a GHC Facility. GHC will cover Emergency care for all Covered Services.

2. At a Non-GHC Facility. Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:

a. Payment of the Emergency care Cost Share; and
b. Notification of GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

3. Waiver of Emergency Care Cost Share.

a. Waiver for Multiple Injury Accident. If two or more Members in the same Family Unit require Emergency care as a result of the same accident, coverage for all Members will be subject to only one (1) Emergency care Copayment.

b. Emergencies Resulting in an Inpatient Admission. If the Member is admitted to a GHC Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Cost Share.

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

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

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

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

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

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

1. **Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule.

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

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

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

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

Section V. General Exclusions

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

1. Services or supplies not specifically listed as covered in the Schedule of Benefits, Section IV.

2. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; take-home drugs, dressings and supplies following hospitalization; and any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section IV.

3. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided in Section IV.D.

4. Convalescent or custodial care.

5. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.E., IV.F. or IV.H.

6. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.

7. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHC for early detection of disease.

8. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.

9. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.

10. Any services to the extent benefits are “available” to the Member as defined herein under the terms of any vehicle, homeowner’s, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to medical coverage, medical “no fault” coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be “available” to the Member if the Member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

The Member and his/her agents must cooperate fully with GHC in its efforts to enforce this exclusion. This cooperation shall include supplying GHC with information about, or related to, ***the cause of injury or illness or*** the availability of other insurance coverage. The Member and his/her agent shall permit GHC, at GHC's option, to associate with the Member or to intervene in any action filed against any party related to the injury. The Member and his/her agents shall do nothing to prejudice GHC's right to enforce this exclusion. ***Failure to fully cooperate, including withholding information regarding the cause of injury or illness or other insurance coverage may result in denial of claims*** and the Member shall be responsible for reimbursing GHC for expenses ***incurred and the value of the benefits provided by GHC under this Agreement for the care or treatment of the injury or illness sustained by the Member***.

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

If this Agreement is not subject to ERISA and reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, under certain conditions GHC will reduce the amount of reimbursement to GHC by the amount of an equitable apportionment of such collection costs between GHC and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) the equitable apportionment of attorney fees has been agreed to by GHC prior to settlement or recovery, (ii) the Injured Person's attorney's action has benefited GHC in its recovery, and (iii) the Injured Person's attorney's actions were reasonable and necessary to secure recovery. GHC's share of collection costs is subject to a maximum responsibility of GHC equal to one-third of the amount recovered on behalf of GHC. Under no circumstance will GHC incur legal fees for services which were not reasonably and necessarily incurred to secure recovery or which do not benefit GHC.

If this Agreement is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of GHC, the Injured Person may request and GHC may reduce the amount of reimbursement to GHC by an amount for reasonable and necessary attorney's fees incurred by the Injured Person on behalf of and for the benefit of GHC, but only if such amount is agreed to by GHC prior to settlement or recovery.

11. Late term pregnancy termination except when the health of the mother is at risk.

12. The cost of services and supplies resulting from a Member's loss of or willful damage to appliances, devices, supplies and materials covered by GHC for the treatment of disease, injury or illness.

13. Orthoptic therapy (i.e., eye training).

14. Specialty treatment programs such as weight reduction, "behavior modification programs" and rehabilitation, including cardiac rehabilitation.

15. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.

16. Procedures and services to reverse a therapeutic or nontherapeutic sterilization.

17. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental service not specifically listed as covered in Section IV. GHC's Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service.

18. Drugs, medicines and injectables, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injectables, including those not listed as covered in the GHC drug formulary (approved drug list), will also exclude their administration.

19. Experimental or investigational services.

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

    a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member.

        i. The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
        ii. The service is the subject of a current new drug or new device application on file with the FDA.
        iii. The service is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the service.
        iv. The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
        v. The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
        vi. The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
        vii. The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

    b. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

        i. The Member's medical records,
        ii. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
        iii. Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
        iv. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
        v. The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
        vi. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

    Appeals regarding ***GHC*** denial of coverage can be submitted to the Member Appeal Department, or to GHC's Medical Director at P.O. Box 34593, Seattle, WA 98124-1593.

20. Chemical dependency, rehabilitation services and mental health care, except as specifically provided in Sections IV.C., IV.G. and IV.K.

21. Hypnotherapy, and all services related to hypnotherapy.

22. Genetic testing and related services, unless determined Medically Necessary by GHC's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in Section IV.B. Testing for non-Members is also excluded.

23. Follow-up visits related to a non-Covered Service.

24. Fetal ultrasound in the absence of medical indications.

25. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.

26. Complications of non-Covered Services.

27. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth in Section IV.B.

28. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a member of the Member's family.

29. Autopsy and associated expenses.

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

31. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.

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

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

Section VI. Grievance Processes for Complaints and Appeals

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

Filing a Complaint or Appeal

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

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

Complaint Process

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

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

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

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

Appeals Process

Step 1: If the Member wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Appeals should be directed to GHC's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, toll free (866) 458-5479.

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

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

There is an expedited appeals process in place for cases which meet criteria or where the Member's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited appeal in writing to the above address, or by calling GHC's Member Appeals Department toll free (866) 458-5479. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

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

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

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

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

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

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

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

   A request for a hearing by the appeals committee must be made within thirty (30) days after the date of the Step 1 decision notice. The request can be mailed to GHC's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593. *

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

Section VII. General Provisions

A. Coordination of Benefits

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. 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, the Member or the Member's provider should file all the Member's claims with each plan at the same time. If Medicare is the Member's primary plan, Medicare may submit the Member's claims to the Member's secondary carrier.

1. Definitions.

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

1) Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

c. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Member has health care coverage under more than one plan.

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

d. 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:

1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
2) If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4) 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.

e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

f. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

2. Order of Benefit Determination Rules.

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

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

b. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a Group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess

to any other parts of the plan provided by the Subscriber. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

c. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

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

1) Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Member as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent, and primary to the plan covering the Member as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
(2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
(3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
(4) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits; or
(5) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the non-custodial parent, third; and then
- The plan covering the spouse of the non-custodial parent, last.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.

3) Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.

4) COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Subscriber or retiree or covering the Member as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.

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

6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

3. Effect on the Benefits of this Plan.

When this plan is secondary, it 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. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. GHC may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the Member claiming benefits. GHC need not tell, or get the consent of, any Member to do this. Each Member claiming benefits under this plan must give GHC any facts it needs to apply those rules and determine benefits payable.

5. Facility of Payment.

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

6. Right of Recovery.

GHC has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. GHC may

recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

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

7. Effect of Medicare.

Members Residing Outside the GHC Medicare Advantage Service Area. Medicare primary/secondary payer guidelines and regulations will determine primary/secondary payer status. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

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

B. Subrogation and Reimbursement Rights

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

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

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

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

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

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

agrees to allow GHC to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHC's Medical Expenses

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

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

If this Agreement is not subject to ERISA and reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, under certain conditions GHC will reduce the amount of reimbursement to GHC by the amount of an equitable apportionment of such collection costs between GHC and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) the equitable apportionment of attorney fees has been agreed to by GHC prior to settlement or recovery, (ii) the Injured Person's attorney's action has benefited GHC in its recovery, and (iii) the Injured Person's attorney's actions were reasonable and necessary to secure recovery. GHC's share of collection costs is subject to a maximum responsibility of GHC equal to one-third of the amount recovered on behalf of GHC. Under no circumstance will GHC incur legal fees for services which were not reasonably and necessarily incurred to secure recovery or which do not benefit GHC.

If this Agreement is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of GHC, the Injured Person may request and GHC may reduce the amount of reimbursement to GHC by an amount for reasonable and necessary attorney's fees incurred by the Injured Person on behalf of and for the benefit of GHC, but only if such amount is agreed to by GHC prior to settlement or recovery.

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

C. Miscellaneous Provisions

1. **Identification Cards.** GHC will furnish cards, for identification purposes only, to all Members enrolled under the Agreement.

2. **Administration of Agreement.** GHC may adopt reasonable policies and procedures to help in the administration of the Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

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

4. **Confidentiality.** GHC and the Group shall keep Member information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.

5. **Nondiscrimination.** GHC does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

Section VIII. Definitions

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

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

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

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

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

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

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

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

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

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: A Subscriber and all his/her Dependents.

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

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

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

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

GHC Personal Physician: A provider who is employed by or contracted with GHC to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which a Member can access

without a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.

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

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

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

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

Medical Condition: A disease, illness or injury.

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

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

Member: Any Subscriber or Dependent enrolled under the Agreement.

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

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

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

A coinsurance percentage not identified as Plan Coinsurance is a benefit specific coinsurance and does not apply to the Out-of-Pocket Limit except as otherwise specified under Section II. Out-of-Pocket Limit.

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

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

Residential Treatment: A term used to define facility-based treatment, which includes twenty-four (24) hours per day, seven (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.

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

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

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

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

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

Group Health Cooperative Medicare Advantage Plan (MA)

Following is a brief outline of the benefits available to Group Members who are also enrolled in the Group Health Cooperative Medicare Advantage (MA) plan.

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

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

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

SUMMARY OF BENEFITS

Group Health Medicare Advantage Clear Care Employer Group Plan (Benefit 2)

If you have any questions about this plan's benefits or costs, please contact Group Health Cooperative for details.

SECTION II – Summary of Benefits

Benefit Category	Original Medicare	GHC Medicare Plan (Medicare Parts A & B)
IMPORTANT INFORMATION		
1 – Premium and Other Important Information	In 2011 the monthly Part B Premium is $96.40 and the yearly Part B deductible amount is $162. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income ($85,000 for singles, $170,000 for married couples).For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	$2,500 out-of-pocket limit. Contact the plan for services that apply.
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists for (for certain benefits). You may have to pay a separate copay for certain doctor office visits.

SUMMARY OF BENEFITS		
INPATIENT CARE		
3 - Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	In 2011 the amounts for each benefit period are: Days 1 - 60: $1,132 deductible Days 61 - 90: $283 per day Days 91 - 150: $566 per lifetime reserve day Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network:** For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments: Days 1-5: $200 copay per day Days 6-90: $0 copay per day $0 copay for additional hospital days. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4 - Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	For Medicare-covered hospital stays you pay the lesser of the Group cost share or the following copayments: Days 1-5: $200 copay per day Days 6-90: $0 copay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: $0 per day Days 21 - 100: $141.50 per day 100 days for each benefit period. A benefit period begins the day you	There is no copayment for services received at a Skilled Nursing Facility. No prior hospital stay is required. You are covered for 100 days each benefit period. Authorization rules may apply.

	go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	
6 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay	Authorization rules may apply. $0 copay for Medicare-covered home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	**General** See “Physical Exams” for more information. Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $20 copay for each primary care doctor office visit for Medicare-covered services. You pay the lesser of the Group cost share or $20 copay for each specialist visit for Medicare-covered services.

9 - Chiropractic Services	Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** You pay the lesser of the Group cost share or $20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).
10 - Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $20 copay for Medicare-covered visits. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $20 copay for each Medicare-covered individual or group therapy visit.
12 - Outpatient Substance Abuse Care	20% coinsurance	**In-Network** $0 copay for Medicare-covered visits.
13 - Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $200 copay for each Medicare-covered ambulatory surgical center visit. You pay the lesser of the Group cost share or $200 copay for each Medicare-covered outpatient hospital facility visit.

14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $150 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	**In-Network** You pay the lesser of the Group cost share or $50 for each Medicare-covered emergency room visit. **Out-of-Network** Worldwide coverage. **In and Out-of-Network** If you are admitted to the hospital within 1 day for the same condition, you pay $0 for the emergency room visit.
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	You pay the lesser of the Group cost share or $20 copay for each Medicare-covered urgently needed care visit.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or $20 for Medicare-covered Occupational Therapy visits. You pay the lesser of the Group cost share or $20 for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered items.
19 - Prosthetic Devices (Includes braces, artificial limbs and eyes,	20% coinsurance	**General** Authorization rules may apply.

etc.)		**In-Network** You pay the lesser of the Group cost share or 20% of the cost for Medicare-covered items.
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	**General** Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. **In-Network** $0 copay for Nutrition Therapy for Diabetes. You pay the lesser of the Group cost share or 20% of the cost for Diabetes supplies.
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests X-rays – Diagnostic radiology services (not including X-rays) – therapeutic radiology services
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered bone mass measurement
23 - Colorectal Screening Exams (for people with	20% coinsurance Covered when you are high risk or	**General** Authorization rules may apply.

Medicare age 50 and older)	when you are age 50 and older.	**In-Network** $0 copay for Medicare-covered colorectal screenings.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	**General** Authorization rules may apply. **In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine No referral necessary for Flu and Pneumonia vaccines. Referral required for other immunizations.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	**In-Network** $0 copay for Medicare-covered screening mammograms.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for pelvic exams.	**In-Network** $0 copay for Medicare-covered pap smears and pelvic exams.
27 - Prostate Cancer Screening Exams (For men with Medicare age 50 and older.)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered prostate cancer screenings.
28 – End-Stage Renal Disease	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by	**General** Authorization rules may apply. Out-of-area Renal Dialysis services do not require Authorization. **In-Network** $0 copay for renal dialysis $0 copay for Nutrition Therapy for end-stage renal disease

	a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	
29 - Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Your Employer Group Outpatient Prescription drug benefit applies. Please contact the plan for details.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	$0 copay for Medicare-covered dental benefits. In general, preventive dental benefits (such as cleaning) not covered.
31 - Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	You pay the lesser of the Group cost share or: - $20 for each Medicare-covered hearing exam (diagnostic hearing exams). Your Employer Group hearing benefit applies for routine exams and hearing aids. Please contact the plan for details.
32 – Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** - $0 copay for one pair of eyeglasses or contact lenses after each cataract surgery. - $20 for exams to diagnosis and treat diseases and conditions of the eye). Your Employer Group Vision benefit applies for routine eye exams and glasses. Please contact the plan for details.

33 - Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	$0 copay for routine exams. Limited to 1 exam every two years. $0 copay for Medicare-covered benefits.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	**In-Network** This plan covers the following health/wellness education benefits: – Smoking Cessation – Health Club Membership/Fitness Classes – Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session
Transportation (Routine)	Not covered.	**General** Authorization rules may apply. **In-Network** $150 copay for one-way trips to a Plan-approved location.

SECTION III – Other Benefits Offered By Group Health's Clear Care Plan

My Group Health (when you get care at a Group Health medical center).

- Request appointments
- View your online medical records
- Email your doctor
- Get test results
- Check your benefits

Wellness Programs

Consulting Nurse helpline 24/7

Prescription Refills

- Online
- Mail-order
- By phone

Senior Caucus

Travel Advisory Service

Group Health Resource Line

Additional Information About Covered Benefits Found in Section II

Skilled Nursing Facility (Group Health Covered): When a 3 day Medicare covered hospital stay does not occur and the plan determines that the member otherwise meets all Medicare criteria for an acute inpatient hospital stay at the time of admission to a Medicare Certified Skilled Nursing Facility, the plan may authorize Medicare covered Skilled Nursing Facility Care up to the Medicare Skilled Nursing Facility day limit per benefit period. All Medicare criteria must be met and the stay must be authorized in advance by the plan.

Out-Of-Pocket Limit; Stop Loss Provision for Copayments: Total copayment expenses for outpatient services and the outpatient supplies listed in this summary of benefits, hospital emergency room visits, ambulance/transportation services, inpatient hospital stays, and inpatient mental health care stays, are limited to an aggregate annual maximum of $2,500 per calendar year per member.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion.

The following items and services aren't covered under Original Medicare or our MA plan (please refer to your employer group Certificate of Coverage for more information about what is covered and excluded under your employer group plan):

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids and routine hearing examinations.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery, and routine eye examinations are covered under our basic benefit.
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than

the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

- Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

YOUR RIGHTS AND RESPONSIBILITES

SECTION 1 Our plan must honor your rights as a member of the plan

We must provide you with details about your rights and responsibilities as a patient and consumer

Section 1.2 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are on the front cover).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.3 We must treat you with fairness, respect, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

Customer Service (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.4 We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Service to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care.

Section 1.5 We must provide access to information about the qualifications of the professionals caring for you

Section 1.6 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice", that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your

medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are on the cover of this booklet).

Section 1.7 We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are on the cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For more detailed information about our providers, you can call Customer Service (phone numbers are on the cover of this booklet) or visit our website at www.ghc.org/medicare.
- **Information about your coverage and rules you must follow in using your coverage.**
    - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.

Section 1.8 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks**. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are on the cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with SHIBA at the Washington State Office of the Insurance Commissioner by writing to SHIBA HelpLine, Office of the Insurance Commissioner, P.O. Box 40256, Olympia, WA 98504-0256, or calling the toll-free SHIBA Helpline at 1-800-562-6900.

Section 1.9 You have the right to give consent to–or refuse–care, and be told the consequences of consent or refusal

Section 1.10 You have the right to have an honest discussion with your practitioner about all your treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your medical condition and ability to understand

Section 1.11 You have the right to join in decisions to receive, or not receive, life-sustaining treatment including care at the end of life

Section 1.12 You have the right to create and update your advance directives and have your wishes honored

Section 1.13 You have the right to choose a personal primary care physician affiliated with your health plan

Section 1.14 You have the right to expect your personal physician to provide, arrange, and/or coordinate your care

Section 1.15 You have the right to change your personal physician for any reason

Section 1.16 You have the right to be educated about your role in reducing medical errors and the safe delivery of care

Section 1.17 You have the right to voice opinions, concerns, positive comments and complaints and to ask us to reconsider decisions we have made

You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are on the cover of this booklet).

Section 1.18 You have the right to appeal a decision and receive a response within a reasonable amount of time

Section 1.19 You have the right to suggest changes to consumer rights and responsibilities and related policies

Section 1.20 You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

Section 1.21 You have the right to be free from all forms of abuse, harassment, or discrimination

Section 1.22 You have the right to be free from discrimination, reprisal, or any other negative action when exercising your rights

Section 1.23 You have the right to request and receive a copy of your medical records, and request amendment or correction to such documents, in accordance with applicable state and federal laws

Section 1.24 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights
If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can call Customer Service (phone numbers are on the cover of this booklet).
- You can call the State Health Insurance Assistance Program.

Section 1.25 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program.**
- You can contact **Medicare.**
    - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are on the cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services****. Use this booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
- ***If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.*** *Please call Customer Service to let us know.*
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you with it.
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care.*
- ***Use practitioners and providers affiliated with your health plan for health care benefits and services, except where services are authorized or allowed by your health plan, or in the event of emergencies.***
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - Provide accurate information, to the extent possible, that Group Health requires to care for you. This includes your health history and your current condition. Group Health also needs your permission to obtain needed medical and personal information. This includes your name, address, phone number, marital status, dependents' status, and names of other insurance companies.
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Understand and follow instructions for treatment, and understand the consequences of following or not following instructions.***
- ***Be considerate****. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices. This includes arriving on time for appointments, and notifying staff if you cannot make it on time or if you need to reschedule.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - You must pay your plan premiums to continue being a member of our plan.
    - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay

a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- **Understand your health needs and work with your personal physician to develop mutually agreed upon goals about ways to stay healthy or get well when you are sick**
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are on the cover of this booklet).*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- ***Call Customer Service for help if you have questions or concerns****. We also welcome any suggestions you may have for improving our plan.*
    - Phone numbers and calling hours for Customer Service are on the cover of this booklet.

COVERAGE DECISIONS, APPEALS, COMPLAINTS

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use **the process for coverage decisions and making appeals.**
- For other types of problems you need to use the **process for making complaints.**
-

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.
Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.
To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.
However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP).** This government program has

trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free.

You can also get help and information from Medicare

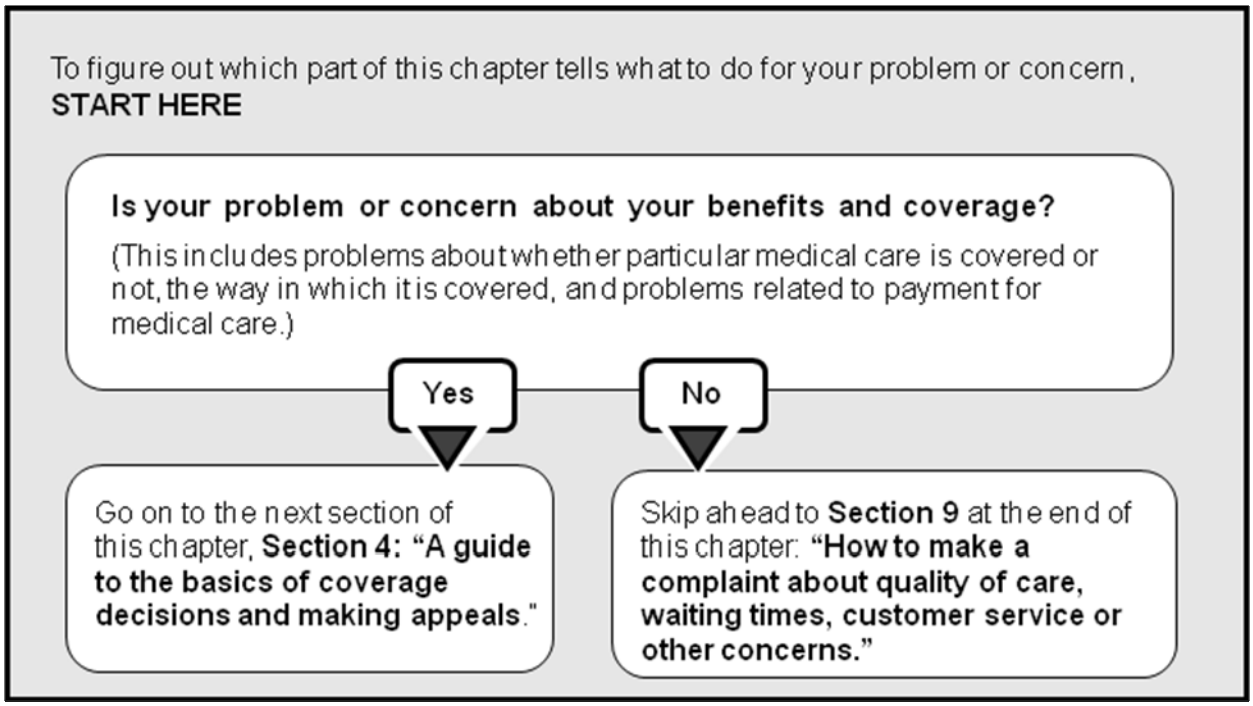
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.



SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. We and/or your doctor make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

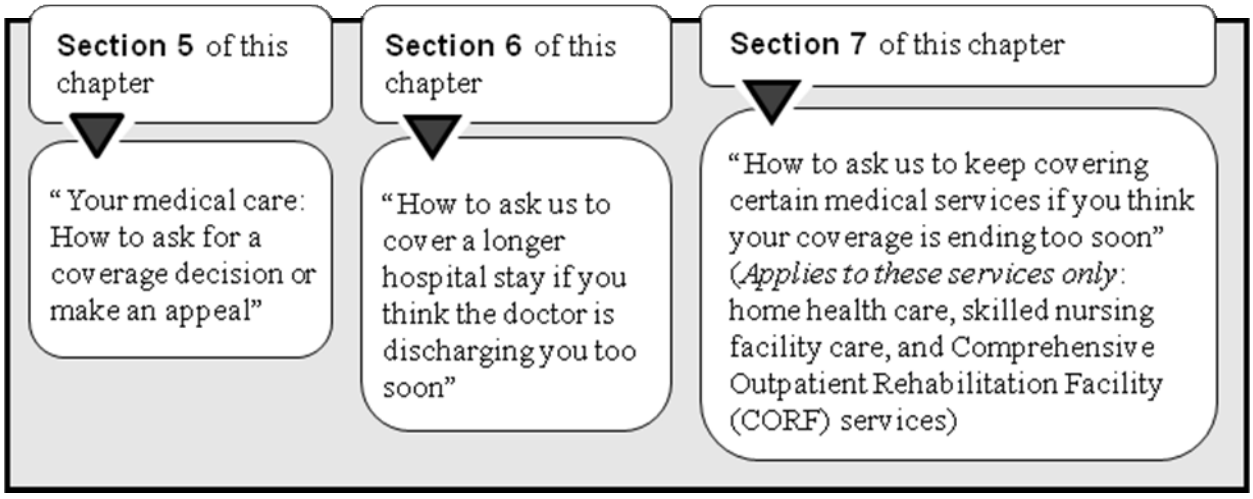
- You **can call us at Customer Service** (phone numbers are on the cover).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your

behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:



If you're still not sure which section you should be using, please call Customer Service (phone numbers are on the front cover). You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (A guide to "the basics" of coverage decisions and appeals)? If not, you may want to read it before you start this section.

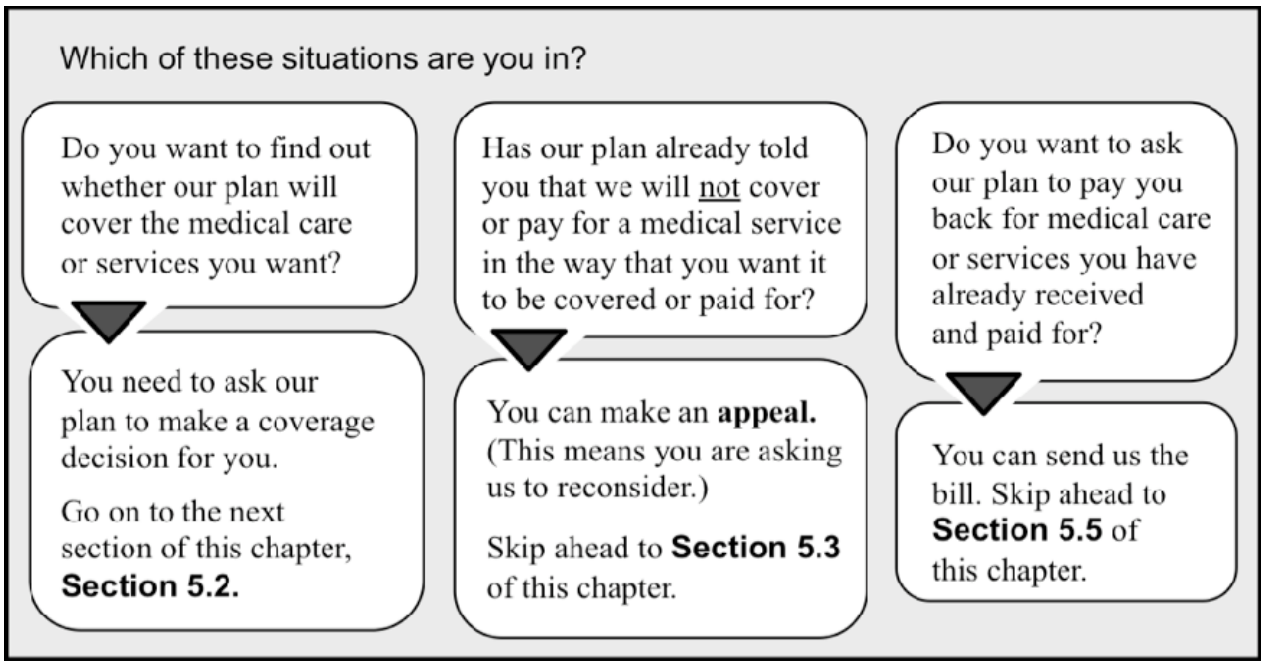
Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in the Summary on Benefits. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.
This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
     - Section 6: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
     - Section 7: *How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

   - For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.



Section 5.2 Step-by-step: How to ask for a coverage decision

(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms	When a coverage decision involves your medical care, it is called an "organization determination."

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "**fast decision.**"

Legal Terms	A "fast decision" is called an "expedited decision."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For

more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

<u>Step 2:</u> Our plan considers your request for medical care coverage and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours.**
  - As explained above, we can take up to 14 more days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If we take extra days, it is called "an extended time period."
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72

hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If our plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3	**Step-by-step: How to make a Level 1 Appeal** (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

<u>Step 1:</u> You contact our plan and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.**

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
- **If you are asking for a fast appeal, make your appeal in writing or call us.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal.
    - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request)

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to do so.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this

section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

<u>Step 3:</u> If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, our plan is required to send your appeal to the "Independent Review Organization." When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the **"IRE."**

<u>Step 1:</u> The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast" appeal at Level 1, you will also have a **"fast" appeal** at Level 2*

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

*If you had a "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2*

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are

requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

<u>Step 3:</u> If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking our plan to pay you for our share of a bill you have received for medical care?

Asking for reimbursement is asking for a coverage decision from our plan
If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?
If you do not agree with our decision to turn you down, **you can make an appeal.** If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.
To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Summary of Benefits.
During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."** Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:

   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - What to do if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.hhs.gov.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an **"immediate review"** or an **"expedited review."**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying no to your appeal is also called turning down your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.
Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review within **60 calendar days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

<u>Step 3:</u> Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

<u>Step 4:</u> If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or "**expedited appeal**").

<u>Step 1:</u> Contact our plan and ask for a "fast review."

- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

<u>Step 2:</u> Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

<u>Step 3:</u> Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our plan says no to your appeal.

<u>Step 4:</u> If our plan says no to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity.**" It is sometimes called the **"IRE."**

<u>Step 1:</u> We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

<u>Step 2:</u> The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

<u>Step 3:</u> If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* **Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility.
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the Summary of Benefits.

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care.*

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.

- The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms	In this written notice, we are telling you about a "**coverage decision**" we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling what you can do, the written notice is telling how you can "**make an appeal**." Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 below tells how you can make an appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/

2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

<u>Step 1:</u> Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization.

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed our plan of your appeal, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms	This notice explanation is called the **"Detailed Explanation of Non-Coverage."**

<u>Step 3:</u> Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then our plan must keep providing your covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services.

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

<u>Step 4:</u> If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to

accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

<u>Step 1:</u> Contact our plan and ask for a "fast review."

- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

<u>Step 2:</u> Our plan does a "fast" review of the decision we made about when to end coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

<u>Step 3:</u> Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

<u>Step 4</u>: If our plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

<u>Step 1</u>: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

<u>Step 2:</u> The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")

- The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

<u>Step 3:</u> If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.
If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.
For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
    - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your

appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
    - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

?

If your problem is about decisions related to benefits, coverage, or payment, then this section *is not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals?
- Or by Member Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.

- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

- When your plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms	• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** • Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step**. If there is anything else you need to do, Customer Service will let you know. Customer Service may be reached by calling 1-888-901-4600 (TTY only, call 1-800-833-6388 or 711). Hours are Monday-Friday, 8 a.m.-8 p.m. From November 15 through March 1, hours are daily, 8 a.m.-8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:
    - For this process your grievance requests must be in writing, and mailed to Group Health Medicare Customer Service Medicare Grievance, P.O. Box 34590, Seattle WA 98124-1590 or fax: 206-901-6205, or From www.ghc.org click "Contact Us." We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal	What this section calls a **"fast complaint"** is also called a **"fast**

Terms	grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or, you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

PREMIUM SCHEDULE

Group Name	**City of Spokane Group Health $10/30 RX $200 VHA**		
Group Number (Primary)	**4983000**		
GROUP HEALTH COOPERATIVE - Group Health benefit description			
Inside the Network: Managed Care Providers			
Coinsurance	None		
Deductible	None		
Emergency Copay	$50/$100		
Family Ded & OOP Max	2x		
Hospital Inpatient Copay	None		
Office Visit Copay	$5		
Optical Rider	$200/24 months		
Out Of Pocket	$2000		
Outpatient Surgery Copay	Same as OV		
Prescription Drug Copay	$10/$30		
No PEC Wait		Group Offering	Dual Choice
MONTHLY HEALTHCARE PREMIUM			
This Schedule reflects from: 01/01/2011 to 01/01/2012			
Subscriber	$580.33		
Subscriber and Spouse	$1,101.60		
Subscriber and 1 Child	$967.92		
Subscriber and 2+ Children	$1,026.99		
Subscriber, Spouse and Children	$1,449.80		
HEALTH CARE DUES FOR MEMBERS WITH MEDICARE COVERAGE			
Medicare entitled with AB Medicare	$194.89		
Subscriber and Spouse, 1 AB Medicare	$716.15		
Subscriber and Spouse, 2 AB Medicare	$389.77		
Subscriber and one Child, 1 AB Medicare	$582.47		
bscriber and two or more Children, 1 AB Medicar	$641.54		
iber,spouse and two or more Children, 1 AB Medicar	$1,064.35		
iber,spouse and two or more Children, 2 AB Medicar	$737.98		