

Dear Group Health Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2003 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. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health for your healthcare coverage.

Certain words, paragraphs, and sections of this certificate have been bolded and italicized. This identifies changes or clarifies language to more accurately reflect Group Health's current administrative or care delivery practices. In addition, other benefit or contract provisions that your employer or association might have requested or negotiated are included in this certificate.

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 for general information at 901-4636 or for Medicare information at 901-4600 in the Seattle area, or toll-free in Washington, 1-888-901-4636 or 1-888-901-4600.

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

Very truly yours,

Cheryl Scott
President

CA-1851

Certificate of Coverage

Group Health Cooperative is a nonprofit, health maintenance organization furnishing health care primarily on a prepayment basis.

Read Your Certificate Carefully

This Certificate of Coverage is a statement of benefits, exclusions, and other provisions as set forth in the Group Medical Coverage Agreement between Group Health Cooperative, also referred to as the Cooperative or GHC, and your employer or Group. Some of the provisions of the Group Medical Coverage Agreement are abridged in this Certificate of Coverage. Refer to the Group Medical Coverage Agreement for complete information or specific details.

A full description of benefits, exclusions, limits and out-of-pocket expenses can be found in Section X. Schedule of Benefits, Section XI. Exclusions and the Allowances Schedule. These sections must be considered together to fully understand the benefits available under your plan.

Accessing Care

MEMBERS ARE ENTITLED TO COVERED SERVICES ONLY AT GH FACILITIES AND FROM GHC **PRIMARY CARE PROVIDERS**. ***EXCEPT AS FOLLOWS:***

- ***Emergency care,***
- ***women's health care providers as set forth below,***
- ***visits with GH-Designated Self-Referral Specialists, as set forth below***
- ***other services as specifically set forth in the Allowances Schedule and Section X.,***
- ***care provided pursuant to a Referral. Referrals must be requested by the Member's primary care provider and approved by GHC.***

Primary Care. ***Members must select a GH Primary Care Provider when enrolling under this Agreement. One primary care provider may be selected for the entire family, or a different primary care provider may be selected for each family member. If the primary care provider is not selected at the time of enrollment, Group Health will assign a primary care provider, and a letter of explanation and an identification card will be sent to the Member.***

Selecting a primary care provider or changing from one Primary Care Provider to another can be accomplished by contacting Group Health 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 Primary Care Providers, referral specialists, women's health care providers, and GH-designated Self-Referral Specialists is available by contacting GHC Customer Service at (206) 901-4636 (or 1-888-901-4636), or by accessing GHC's website at www.ghc.org.

In the case that the Member's primary care provider no longer participates in GHC's network, the Member will be provided a written notice offering the Member a selection of new primary care providers from which to choose.

Specialty Care. ***Unless otherwise indicated in this section, the Allowances Schedule, or Section X, referrals are required for specialty care and specialist.***

GH Designated Self-Referral Specialist. ***Members may make appointments directly with GH-Designated Self-Referral Specialists at GH-owned or operated medical centers without a Referral from their primary care provider. 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 a Referral 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 to provide women's health care services directly, without a Referral from their Primary Care Provider, for Medically Necessary and appropriate maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care, and medically appropriate follow-up visits for the above services. Women's health care services are covered as if your Primary Care Provider had been consulted, subject to any applicable Copayments and/or Coinsurance as set forth in the Allowances Schedule. If your women's health care provider diagnoses a condition that requires referral to other specialists or hospitalization, you or your 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 and urgent care services are covered as set forth in Section X.L. Contact the Emergency Notification Line as indicated on your GH identification card.*

Recommended Treatment. *The Cooperative'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. Coverage decisions may be appealed as set forth in Section VII.*

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. In such case, GHC shall have no further obligation to provide benefits for the condition in question.

Non-Recommended Treatment. *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.*

Major Disaster or Epidemic. *In the event of a major disaster or epidemic, GHC will provide coverage according to its best judgment, within the limitations of available facilities and personnel. The Cooperative 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 the Cooperative have any liability or obligation on account of delay or failure to provide or arrange such services.*

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ALLOWANCES SCHEDULE

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

ANNUAL DEDUCTIBLE

\$500 per Member or \$1,500 per Family Unit per calendar year

PLAN COINSURANCE

80% of charges are covered, after the annual Deductible is satisfied.

LIFETIME MAXIMUM

No lifetime maximum *unless otherwise indicated*.

HOSPITAL SERVICES

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

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- *Covered outpatient hospital surgery (including ambulatory surgical centers)*

Covered subject to the applicable outpatient services Copayment and plan coinsurance after the annual deductible is satisfied.

OUTPATIENT SERVICES

- *Covered outpatient medical and surgical services*

Covered subject to a \$20 Copayment and the plan Coinsurance after the annual Deductible is satisfied.

- *Allergy testing*

Covered subject to the outpatient services Copayment and plan Coinsurance after the Annual Deductible is satisfied.

- *Oncology (radiation therapy, chemotherapy)*

Covered subject to the outpatient services Copayment and plan Coinsurance after the Annual Deductible is satisfied.

DRUGS - OUTPATIENT (including mental health drugs, contraceptive drugs and devices and diabetic supplies)

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

Covered subject to the lesser of GHC's charge or a \$15 Copayment for generic drugs or \$30 Copayment for brand name drugs.

- *Over-the-counter drugs and medicines*

Not covered.

- *Allergy serum*

Covered subject to the prescription drug Copayment for each 30 day supply.

- *Injectables*

Injections that can be self-administered are subject to the plan Coinsurance after the annual Deductible is satisfied.

- *Mail order drugs and medicines*

A 90-day supply of mail order prescription drugs are covered subject to a \$30 Copayment for generic drugs or \$60 Copayment for brand name drugs.

- *Growth hormones*

Covered subject to the plan Coinsurance after the annual Deductible is satisfied. A 12 month waiting period applies.

OUT-OF-POCKET LIMIT (STOP LOSS)

Except as otherwise noted in this Allowances Schedule, total out-of-pocket expenses for the following Covered Services:

- Plan Coinsurance
- Emergency Care at a GH, GH Designated or non-GH Facility
- Ambulance services

Limited to an aggregate maximum of \$2,000 per Member and \$6,000 per family per calendar year.

ACUPUNCTURE

Self-referrals to a GHC Provider covered up to a maximum of five (5) visits per Member per medical diagnosis per calendar year, subject to the applicable outpatient services copayment and plan coinsurance after the annual deductible has been satisfied. Additional visits are covered when approved by GHC subject to the applicable outpatient services copayment and plan coinsurance after the annual deductible has been satisfied.

AMBULANCE SERVICES

- Emergency ground/air transport.

Covered at 80%.

- Non-emergent transfer to a GH or GH Designated Facility

Covered in full.

CHEMICAL DEPENDENCY

- Inpatient Services

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- Outpatient Services

Covered subject to the applicable outpatient services Copayment and plan Coinsurance after the annual Deductible is satisfied.

- Benefit Period Allowance

\$11,285 maximum per Member per any 24 consecutive month period.

Acute detoxification covered as any other medical service. Not subject to 24 month maximum.

DENTAL SERVICES (including accidental injury to natural teeth)

Not covered.

DEVICES, EQUIPMENT AND SUPPLIES (for home use)

- Orthopedic appliances when listed as covered in the orthopedic appliance formulary
- Durable medical equipment when listed as covered in the durable medical equipment formulary
- Prosthetic devices when listed as covered in the prosthetic device formulary
- Ostomy supplies
- Oxygen and oxygen equipment
- Post-mastectomy bras (limited to two every 6 months)

Covered at 80%. Coinsurance does not apply to Stop Loss.

DIABETIC SUPPLIES

Insulin, needles, syringes and lancets covered under Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies covered under Devices, Equipment and Supplies.

DIAGNOSTIC LABORATORY AND RADIOLOGY SERVICES

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

EMERGENCY SERVICES

- At a GH or GH Designated Facility

Covered subject to a \$75 Copayment per Emergency visit per Member and plan Coinsurance, after the annual Deductible is satisfied. Copayment is waived if Member is admitted directly from the Emergency department. Emergency admissions are subject to the plan Coinsurance after the annual Deductible is satisfied.

- At a non-GH Designated Facility

Covered subject to a \$125 Deductible per Emergency visit per Member and plan Coinsurance, after the annual Deductible is satisfied. ***Emergency care Deductible is not waived if Member is admitted to the hospital.*** Emergency admissions are subject to the emergency Deductible and plan Coinsurance after the annual Deductible is satisfied.

HEARING EXAMINATIONS AND HEARING AIDS

Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services Copayment and plan Coinsurance after the annual Deductible is satisfied. Hearing aids, including hearing aid examinations, are 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)

Not covered.

MANIPULATIVE THERAPY

Self-referrals *to a GHC Provider* covered for manipulative therapy of the spine in accordance with GHC *clinical criteria* up to a maximum of ten (10) visits per Member per calendar year, subject to the applicable outpatient services Copayment and plan Coinsurance after the annual Deductible is satisfied. Additional *manipulation* visits *are covered when approved by GHC*.

MATERNITY AND PREGNANCY SERVICES

- Delivery and associated hospital care

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- *Routine* prenatal and postpartum care

Covered subject to the applicable outpatient services copayment and plan Coinsurance after the annual Deductible is satisfied.

- *Pregnancy termination*

Involuntary/voluntary termination of pregnancy is covered subject to applicable outpatient services Copayment and plan coinsurance after the annual deductible is satisfied.

MENTAL HEALTH SERVICES

- Inpatient Services

Covered up to 12 days per Member per calendar year at a GH-approved mental health care facility when authorized in advance by GHC, subject to the plan Coinsurance after the annual Deductible is satisfied. Coinsurance does apply to Stop Loss.

- Outpatient Services

Twenty (20) visits covered per Member per calendar year subject to \$30 Copayment per individual/family/couple session and \$20 Copayment per Member per group session, subject to the plan Coinsurance after the annual Deductible is satisfied; no coverage after twenty (20) visits per calendar year. Copayment does not apply to Stop Loss. Medication monitoring visits are subject to the plan Coinsurance after the annual Deductible is satisfied.

NATUROPATHY

Self-referrals to a GHC Provider covered up to a maximum of two (2) visits per Member per medical diagnosis per calendar year, subject to the applicable outpatient services copayment and plan coinsurance after the annual deductible has been satisfied. Additional visits are covered when approved by GHC subject to the applicable outpatient services copayment and plan coinsurance after the annual deductible has been satisfied.

NUTRITIONAL SERVICES

- *PKU supplements*

Covered in full.

- *Enteral therapy (formula)*

Elemental formulas for malabsorption problems are covered at 80% after the annual deductible is satisfied. Coinsurance does not apply to Stop Loss. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

- *Parenteral therapy (total parenteral nutrition)*

Covered subject to the plan coinsurance after the annual deductible is satisfied. Necessary equipment and supplies covered under Devices, Equipment and Supplies.

OBESITY RELATED SERVICES

Bariatric surgery covered subject to the plan coinsurance after the annual deductible is satisfied. Weight loss programs and 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 once every 12 months, subject to the applicable outpatient services Copayment. Lenses (including contact lenses) and frames are not covered. Contact lenses after cataract surgery covered subject to the plan Coinsurance after the annual Deductible is satisfied, when in lieu of intraocular lens.

ORGAN TRANSPLANTS

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

PLASTIC & RECONSTRUCTIVE SERVICES (Plastic Surgery, Cosmetic Surgery)

Surgery is covered to correct a congenital disease or anomaly, or *conditions resulting from* injury or incidental to surgery, *covered* subject to the plan Coinsurance after the annual Deductible is satisfied. Cosmetic surgery, including complications, is excluded.

PODIATRIC SERVICES

- *Medically Necessary foot care*

Covered subject to the applicable outpatient services copayment and plan Coinsurance after the annual Deductible is satisfied.

- *Foot care (routine)*

Not covered except in the presence of a non-related medical condition affecting the lower limbs.

PRE-EXISTING CONDITION

Covered, *after* no wait.

PREVENTIVE (WELL ADULT AND WELL CHILD) SERVICES (Physicals, Immunizations, Pap Smears, Well-care, Mammograms)

- Preventive care visits according to the “well-child” and “well-adult” schedules
- Routine mammography screening

Covered subject to the outpatient services Copayment. Not subject to the annual Deductible or plan Coinsurance. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with preventive care criteria are subject to the applicable outpatient services Copayment and plan Coinsurance after the annual deductible is satisfied.

REHABILITATION SERVICES

- Inpatient physical, occupational and speech therapy services combined, plus associated hospital services for the purpose of rehabilitation, including neurodevelopmental therapy for children age six (6) and under, up to a maximum of sixty (60) days per condition per calendar year

Covered subject to the plan Coinsurance after the annual Deductible is satisfied.

- Outpatient physical, occupational and speech therapy services combined, including neurodevelopmental therapies for children age six (6) and under, are covered up to a maximum of sixty (60) visits per condition per calendar year

Covered at the applicable outpatient services Copayment and plan Coinsurance after the annual Deductible is satisfied.

SEXUAL DYSFUNCTION SERVICES

Not covered.

SKILLED NURSING FACILITY (SNF)

Covered up to sixty (60) days per Member per calendar year, subject to the plan Coinsurance after the annual Deductible is satisfied.

STERILIZATION (Vasectomy, Tubal Ligation)

Covered subject to the applicable outpatient services Copayment and plan Coinsurance after the annual Deductible is satisfied.

TEMPOROMANDIBULAR JOINT (TMJ) SERVICES

- Inpatient and outpatient TMJ services including hospital/office visit charges

\$1,000 maximum per Member per calendar year, subject to the applicable Copayment and plan Coinsurance after the annual Deductible is satisfied.

- Lifetime Maximum Benefit

\$5,000 per Member.

TOBACCO CESSATION

- Individual/Group Sessions

1175600-C22116

Covered at 100% of the total charges.

- Approved pharmacy products

Covered subject to the outpatient prescription drug Copayment for each (30) day supply or less of a prescription or refill when provided at GH Facilities and prescribed by a GHP Provider.

Enrollment/Eligibility Requirements

Effective Date of Enrollment.

a. ***Provided application for enrollment is made as set forth in Section IX.A.1.b.***

- Enrollment for a newly eligible Subscriber and listed Dependents is effective for employees whose applications are received in the District's Payroll Office by the twentieth (20th) of the month, on the first (1st) of the month following the date of hire.

Enrollment for a newly eligible Subscriber and listed Dependents is effective for employees whose applications are received in the District's Payroll Office after the twentieth (20th) of the month, on the first (1st) of the second (2nd) month following the date of hire

- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective the first (1st) of the month following the date of eligibility.
- ***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 has assumed financial responsibility for the medical expenses of the child.

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

Eligibility

In order to be accepted for enrollment and continuing coverage under the Group Agreement, individuals must 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 when approved in advance by GHC, other unique family arrangements. GHC has the right to verify eligibility.

1. Subscribers. Bona fide employees who are employed in a permanent position requiring the equivalent of half-time or more shall be eligible for enrollment.
2. Family Dependents. The Subscriber may enroll any of the following:
 - a. The Subscriber's legal spouse;
 - b. The Subscriber's domestic partner, provided that application has been submitted to and approved by the Group and GHC, and that the domestic partners:
 - i. share the same regular and permanent residence;
 - ii. have a close personal relationship;
 - iii. are jointly responsible for "basic living expenses" as defined by the Group;
 - iv. are not married to anyone;
 - v. are each eighteen (18) years of age or older;
 - vi. are not related by blood closer than would bar marriage in the State of Washington;
 - vii. were mentally competent to consent to contract when the domestic partnership began; and
 - viii. are each other's sole domestic partner and are responsible for each other's common welfare.

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

- c. Unmarried dependent children who are under the age of twenty-three (23), provided they reside regularly with the Subscriber or are chiefly dependent on the Subscriber for support and maintenance, provided proof of such dependency is furnished to GHC.

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

- d. Enrollment may be extended past the limiting age for an unmarried person enrolled as a Family Dependent on his/her twenty-third (23rd) birthday if the Dependent is totally incapable of self-sustaining employment because of a developmental disability or a physical handicap incurred prior to attainment of the limiting age as set forth in 2.c. (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 the GH upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.
- e. **Temporary Coverage for Ineligible Newborns.** A child born to a covered Member who does not otherwise qualify as an eligible dependent as set forth in this section will be entitled to the benefits set forth in Section X. 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 this Agreement. All contract provisions, limitations, and exclusions will apply except Section IV. Continuation of Coverage, Conversion, and Transfer.

In regard to temporary coverage, continuation of coverage benefits set forth in Section IV. will not apply.

Ineligible Persons. 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.

Continuation of Enrollment

While on a group approved leave of absence the Subscriber and listed Dependents can continue to be covered under this Agreement, provided they remain eligible for coverage, such leave is in compliance with the employer's established leave of absence policy consistently applied to all employees, the employer's leave policy is in compliance with the Family and Medical Leave Act when applicable, and the employer or Group continues to remit premiums for the Subscriber and Dependents to the Cooperative.

Section I. Definitions

AGREEMENT: This Medical Coverage Agreement, including the Schedule of Benefits, Enrollment Schedule, Premiums Schedule, Allowances Schedule, *Group Master Application* and Medicare endorsements.

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

COINSURANCE: An amount the Member is required to pay for Covered Services received under this Agreement, which is a percentage of the Allowance for such services, as set forth in the Allowances Schedule.

COPAYMENT: The specific dollar amount required to be paid by a Member for certain Covered Services under this Agreement as set forth in the Allowances Schedule.

COVERED SERVICES: The services *for* which a Member is entitled *to coverage* under this Agreement.

DEDUCTIBLE: A specific maximum amount paid by a Member for certain Covered Services before benefits are payable under this Agreement. The applicable Deductible amounts are set forth in the Allowances Schedule.

DURABLE MEDICAL EQUIPMENT: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury, shall be used in the Member's home, and is limited to items listed as covered in GHC's Durable Medical Equipment Formulary. "Member's home" shall not include a nursing, convalescent, or rest home, hospital or skilled nursing facility.

EMERGENCY: The sudden, unexpected onset of a medical condition that in the reasonable judgment of a prudent person is of such a nature that failure to render immediate care by a licensed medical provider would place the Member's life in danger, or cause serious impairment to the Member's health.

FAMILY DEPENDENT: Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder, and for whom the premiums prescribed in the Premiums Schedule have been paid.

FAMILY UNIT: A Subscriber and all his/her Family Dependents.

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

GH DESIGNATED FACILITY: A facility, not including a GH Facility, which GHC has specified to provide health care services to its Members. Designated Facilities may be changed by GHC upon appropriate notice.

GH DESIGNATED SELF-REFERRAL SPECIALISTS: *A designated self-referral specialist is a GHC specialist specifically identified in the Accessing Care section of this Agreement.*

GH FACILITY: A hospital or medical center owned and operated by Group Health Cooperative.

GH PRIMARY CARE PROVIDER: A provider (*also referred to as "PCP" or "primary care 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 this Agreement which a Member can access without referral. Primary Care Providers must be capable of and licensed to provide the majority of primary health care services required by each Member.

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

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 persons enrolled under this Agreement, and who at such time is providing services which have been authorized in advance by GHC, including, but not limited to, 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 RCW.

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.

MEDICAL CONDITION: A medical condition is a disease, an illness or an injury.

MEDICALLY NECESSARY: Appropriate and necessary services, as determined by the 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*. Services must be medically *and clinically* necessary for benefits to be provided *under this Agreement*. The cost of services and supplies which are not Medically Necessary shall be the responsibility of the Member. *In order to be Medically Necessary, services* and supplies must meet the following requirements: (a) are not solely for the convenience of the patient, 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 patient; (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 not primarily for research and data accumulation; (f) 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 patient's condition or the quality of health services rendered; (g) as to inpatient care, could not have been provided in a physician's office, the outpatient department of a hospital, or a non-residential facility without affecting the patient's condition or quality of health services rendered; 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 the GHC Medical Director, or his/her designee.

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

MEMBER: Any Subscriber or Family Dependent covered by this Agreement.

OPEN ENROLLMENT: An annual period, specified by the Group and GHC, during which an eligible person may apply for coverage.

OUT-OF-POCKET LIMIT (STOP LOSS): The maximum amount of Copayments, and expenses incurred and paid, during the calendar year for Covered Services received by the Subscriber and his/her Family Dependents within the same calendar year. The Out-of-Pocket Limit amount is set forth in the Allowances Schedule. Services in excess of any benefit level, and services not covered by this Agreement are not applied to the Out-of-Pocket Limit.

PRE-EXISTING CONDITION: A condition for which there has been diagnosis, treatment (including prescribed drugs), 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 referral agreement *requested* in advance by a GHC Provider and approved by GHC, which 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 this Agreement. Members who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services.

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

SKILLED HOME HEALTH CARE: 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.

STOP LOSS: *See Out-of-Pocket Limit*

SUBSCRIBER: A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled hereunder, and for whom the premiums specified in the Premiums Schedule have 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-GH Provider. Expenses are considered Usual, Customary, and Reasonable if (1) the charges are consistent with those normally charged by the provider or organization for the same services or supplies; and (2) the charges are within the general range of charges made by other providers in the same geographical area for the same service or supplies.

Section II. Premiums, Fees, and Copayments

A. FEES. The Subscriber shall be liable for the following, as set forth in this section, when services are received by the Subscriber and any of his/her Family Dependents.

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

- 1. Copayments.** At the time of service, Members shall be required to pay Copayments 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.** After the annual Deductible is satisfied, services covered under Section X. Schedule of Benefits are payable at the plan Coinsurance percentage as set forth in the Allowances Schedule.

A benefit-specific Coinsurance as set forth in the Allowances Schedule applies to some Covered Services under the Schedule of benefits.

Services subject to the benefit-specific Coinsurance are not subject to the plan Coinsurance.

- 3. Annual Deductible.** All Covered Services set forth in this Agreement are subject to an annual Deductible. The total charges for Covered Services shall be borne by the Subscriber until the annual Deductible shown in the Allowances Schedule is met. In order to be applied against the annual Deductible, all Covered Services must be obtained at GH Facilities or GH Designated Facilities unless the Member has received a Referral from a GHC Provider or has received Emergency services according to Section X.L. of the Schedule of Benefits.

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

- 4. Individual Annual Deductible Carryover.** Expenses applied toward the individual annual Deductible and incurred for Covered Services received by a Member during the months of October, November and December are also applied in an equal amount toward the Member's annual Deductible for the next calendar year. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate Family Unit Deductible does not carry over into the next calendar year.
- 5. Stop Loss.** The maximum out-of-pocket expenses incurred in any one calendar year for Copayments and annual deductible expenses as set forth in this section shall be limited to the Stop Loss amount as set forth in the Allowances Schedule.
- 6. Other Deductibles.** In addition to the annual Deductible, there are service-specific Deductibles when Emergency care are received as specified in Section X.L.
- 7. Non-Covered Services.** Payment for non-Covered Services must be received within thirty (30) days of the billing date.

B. SUBSCRIBER'S LIABILITY. The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premiums, if any; (2) payment of Copayments, the annual Deductible and/or Coinsurance amounts for Covered Services provided to the Subscriber and his/her Family 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 Family Dependents, at the time of service.

C. SELF-PAYMENTS DURING A STRIKE, LOCK-OUT, OR OTHER LABOR DISPUTE. 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 this 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 Group Agreement is no longer available, the Subscriber shall have the opportunity to apply for individual Group conversion or, if applicable, continuation coverage (see Section IV.), 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.

Section III. Termination

A. TERMINATION OF SPECIFIC MEMBERS. This Agreement may be terminated as to a specific Member for any of the following reasons:

1. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in *the Enrollment/Eligibility Requirements*, and is not enrolled for continuation coverage as described in Section IV.A., coverage under this Agreement will terminate at the end of the month during which loss of eligibility occurs, unless otherwise specified by the Group as set forth in the Enrollment/Eligibility Requirements.
2. **For Cause.** Coverage of a Member may be terminated upon written notice for:
 - a. Material misrepresentation, fraud, or omission of information in order to obtain coverage. This includes failure to answer fully and correctly all questions contained in the application forms. In such event, the Cooperative may, within two (2) years from the date of the application, refuse to cover any service for a condition(s) to which such question was relevant, or may nonrenew or cancel the Member's coverage upon ten (10) working days written notice.
 - b. Permitting the use of a GHC identification card by another person, or using another person's identification card to obtain care to which one is not entitled.
 - c. Nonpayment of charges as set forth in Section II.C.
3. Nonpayment of premiums or contribution for a specific Member by the Group.
4. 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 this Agreement.
5. **Nonpayment of Copayments and Coinsurance.** Failure to pay Copayments in accordance with Section II.A.1 and II.A.2 shall result in termination of the Subscriber upon notice by the Cooperative.
6. **Nonpayment of Deductibles.** Failure to pay Deductibles in accordance with Section II.A.3 shall result in termination of the Subscriber upon notice by the Cooperative.
7. **Nonpayment of Fees for Non-Covered Services.** Failure to pay any fees in accordance with Section II.A.7. shall result in termination of the Subscriber upon notice by the Cooperative.
8. The Member may appeal the termination decision through GHC's grievance process as set forth in Section VII.

B. PERSONS HOSPITALIZED ON THE DATE OF TERMINATION. A Member who is receiving Covered Services *as a registered bed patient* in a GH Facility or GH Designated Facility on the date of termination shall continue to be eligible for Covered Services *while an inpatient* for the condition for which the Member was hospitalized, until *the first of the following events occur*:

- *The Member no longer meets medical criteria to be an inpatient at the facility;*
- *The remaining benefits available under this Agreement for the confinement are exhausted, regardless of whether a new calendar year begins;*
- *The Member becomes covered under another Agreement with the group health plan that provides benefits for the confinement;*
- *The Member becomes enrolled under an Agreement with another carrier that would provide benefits for this confinement if this Agreement did not exist;*
- *Medicare eligibility.*

This provision will not apply if the Member is covered under an Agreement that provides benefits for the confinement 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 Section IV.

This continued coverage will also apply to a Member hospitalized in a non-GH Designated Facility as a result of an Emergency or Referral.

- C. SERVICES PROVIDED AFTER TERMINATION.** Any services provided by GHC after the effective date of termination (except those services covered under Section III.C.) shall be charged according to the Fee Schedule. The Subscriber shall be liable for payment of all such charges for services provided to the Subscriber and all Family Dependents.

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 this Agreement) will be issued automatically upon termination of coverage, and may also be obtained upon request.

Section IV. Continuation Coverage, Conversion and Transfer

A. CONTINUATION COVERAGE UNDER FEDERAL LAW.

This subsection A. only applies to employer 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 the federal Consolidated Omnibus Budget Reconciliation Act of 1985 and amendments thereto (collectively "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.

B. GHC GROUP CONVERSION PLAN.

- 1. Eligibility.** Any Subscriber or Family Dependent *not entitled to Medicare may* convert to GHC's Group Conversion Plan if his/her coverage under this Agreement is terminated for any reason other than cause. (See Section III.B.2.) Following termination of marriage or death of the Subscriber, all Family Dependents are entitled to make such a conversion.
- 2. Application.** Application for conversion must be made within thirty-one (31) days following termination under this Agreement. Coverage under the GHC Group Conversion Plan is subject to all terms and conditions of such plan, including premiums payment. A physical examination or statement of health is not required for enrollment in the Group Conversion Plan. The Pre-existing Condition limitation under the Group Conversion Plan will apply only to the extent that the limitation remains unfulfilled under this 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 Group Health Individual and Family coverage should contact GH Marketing.

- C. CONTINUATION OPTION.** *A Member no longer eligible for coverage under this Agreement (except in the event of termination for cause) may continue coverage for a period of up to three (3) months subject to notification to and self-payment of premium 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).*

Section V. Coordination of Benefits

The Subscriber is an eligible employee of a company who is enrolled under a medical plan offered by the employer, and is entitled to receive benefits and services provided by the plan.

As described below, benefits provided under the Group Medical Coverage Agreement *are subject to this provision.*

"Allowable expense" means any necessary, reasonable and customary items of expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered an allowable expense.

The Coordination of Benefits Standards describe the method of deciding which medical plan will determine its benefits first (the primary plan), and which medical plan will be the secondary plan. The secondary plan pays eligible charges after the primary plan has determined its full benefit payment.

When two (2) health care plans are in effect and one of the plans does not have a coordination of benefits provision and is a self-insured plan, it may elect to be always excess, in which case the plan that includes a coordination of benefits provision is primary. If both plans

have such a provision, the plan covering the patient as an employee will be primary. The plan covering the patient as the spouse of an employee will be secondary.

Where a dependent is covered under more than one Subscriber's plan, the benefits of a plan which covers a dependent of an employee whose date of birth occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of an employee whose date of birth occurs later in a calendar year, except for a dependent child whose parents are separated or divorced. This birth date refers only to the month and day, not the year, in which a person was born.

If parents of a dependent child are separated or divorced, the plan covering the parent with custody is primary unless a court decree establishes that the parent without custody is financially responsible for the health care expenses of the child, in which case such parent's plan is primary. If the parent with custody has remarried, the benefits of the plan that covers the child as a dependent of the parent with custody shall be determined before the benefits of the plan that covers that child as a dependent of the stepparent. The benefits of a plan that covers the child as a dependent of the stepparent will be determined before the benefits of the plan that covers the child as a dependent of the parent without custody.

If none of the above rules determine the order of benefits, then the plan that has covered the Member for the longer period of time shall be determined before the benefits of a plan that has covered such person the shorter period of time, provided that if one of the two plans is a laid off or retired employee plan, the plan of the person that is actively employed will be primary and the plan of the laid off or retired employee will be secondary. If either plan does not have a provision regarding laid off or retired employees, then the above provision shall not apply.

If the above rules still do not determine the order of benefits, the benefits of the plan that covered an employee or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

In order to ensure appropriate coordination of benefits and timely payment, the Member must submit all charges for services received from non-GHC providers to both Group Health Cooperative and the other medical plan at the same time. The Member is responsible for notifying GHC to submit charges for covered services received from a GHC provider to the other medical plan.

This provision does not apply to any individual insurance policy or contract. Refer to the Group Medical Coverage Agreement for a complete explanation.

Effect of Medicare (for those Members residing outside the Group Health Medicare+Choice service area):

For GHC Members eligible for Medicare, Medicare secondary payor guidelines and regulations will determine who is primary.

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

Section VI. Subrogation and Reimbursement Rights

"Injured person" under this section means a Member covered by this Agreement who sustains compensable 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. "GHC's medical expenses" means the expense incurred and the reasonable value of the services provided by GHC for the care or treatment of the injury sustained.

If the injured person's injuries were caused by a third party giving rise to a claim of legal liability against the third party, 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.

If the injured person who receives GHC's medical expenses is entitled to 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 proceeds, then GHC's medical expenses provided or to be provided to the injured person are secondary, not primary, and will be paid only if the injured person fully cooperates with the terms and conditions of this Agreement. As a condition of receiving benefits under this 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. 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. Full compensation shall be measured on an objective case by case basis unless the injured

person settles with the at fault party prior to trial for less than available policy limits in which case full compensation shall be the amount of the settlement.

The injured person and his or her agents must cooperate fully with GHC in its efforts to collect GHC's medical expenses. This cooperation shall include supplying GHC with information about any defendants and/or insurers related to the injured person's claim. The injured person and his or her agents shall permit GHC, at GHC's option, to associate with the injured party or to intervene in any action 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.

The injured person and his or her agents shall do nothing to prejudice GHC's subrogation and reimbursement rights. The injured person shall promptly notify GHC of a tentative settlement and shall not settle a claim without protecting GHC's interest. If the Member fails to cooperate fully with GHC in recovery of medical expenses as described above, the Member shall be responsible for reimbursing GHC for such medical expenses.

To the extent that the injured person recovers from any available source, the injured person agrees to hold such monies in trust or in their possession until GHC's subrogation and reimbursement rights are fully determined.

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

If it becomes necessary for GHC to enforce the provision of this section by initiating any action against the injured person or his or her agent, then the injured person agrees to pay GHC's attorney's fees and costs associated with the action.

Implementation of this section shall be deemed a part of claims administration under this Agreement and GHC shall therefore have sole discretion to interpret its terms.

Section VII. Grievance Procedures for Complaints and Appeals

A grievance is a complaint or appeal as 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 appeal process is available for a Member to seek reconsideration of a denial of benefits.

Complaint Handling

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

Step 2: If the Member is not satisfied, or if he or 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 or she is having a problem. That person will investigate the Member's concerns. Most concerns can be resolved in this way. However, if the Member is still dissatisfied, they should call the Customer Service Center.

Step 3: Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his or her concerns and to state what he or she thinks would be a fair resolution to the problem. A customer service representative or service quality 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 type of complaint can take up to 30 days to resolve after receipt of your written statement.

If the Member is dissatisfied with the resolution of the complaint, he or she may contact the service quality coordinator or the Customer Service Center to appeal. A decision regarding the appeal will be made within 30 days and written notice of the decision will be provided to the Member.

Appeals Process

Step 1: If the Member wishes to appeal a decision, he or she must submit a request for appeal *either orally or in writing* within 180 days of the denial notice he or she received. The Member must specify why he or she disagrees with the decision. GH will notify the Member of its determination or request the Member's written permission for an extension of time within 30 days of receipt of the request for appeal.

If the Member is located west of the Cascade mountains, to GH's Appeals Department, PO Box 3493, Seattle WA 98124-1593, (206) 901-7359 (toll free 1-888-901-4636); or if the Member is located east of the Cascade mountains, to GH's Appeals Department, P.O. Box 204, Spokane, WA 99224-0204, (509) 838-9100 (toll free 1-800-497-2210).

If the appeal request is for an experimental or investigational exclusion or limitation, GH will make a determination and notify the Member in writing within 20 working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GH will notify the Member in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed **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 doctor states clinical urgency exists. If a delay would jeopardize the Member's life, or materially jeopardize the Member's health, the Member can request an expedited appeal in writing to the above address, or by calling GH's Appeals Department in western Washington at (206) 901-7359 (toll free 1-888-901-4600) or in eastern Washington at 1-509-838-9100 (toll free 1-800-497-2210) and ask to be connected with the Appeals Department. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two hours after receipt.

If GH fails to grant or reject the Member's request within the applicable required timeframe, the Member may proceed as if the appeal had been rejected.

Step 2: If the Member is not satisfied with the decision reached by the appeals coordinator regarding a denial of benefits, he or she may request a hearing by the appeals committee by submitting the appeal within 30 days of the date of the decision letter: if the Member is located west of the Cascade mountains, to GH's Appeals Department, PO Box 34593, Seattle WA 98124-1593, or if the Member is located east of the Cascade mountains to GH's Appeals Department, PO Box 204, Spokane, WA 99224-0204.*

The appeals committee is the final review authority within GH. Its decisions are final. Members are encouraged to present their case to the appeals committee in person. ***The hearing and written notification to the Member of the appeals committee decision, will be made within thirty working days of the Member's request.***

Step 3: If the Member is not satisfied with the committee's decision, or if GH exceeds the timeframes stated in Step 1 and 2 above without good cause and without reaching a decision, his or her final level of appeal is available through an independent review organization. An independent review organization is not legally affiliated or controlled by GH.*

*If the Member's health plan is governed by ERISA (most employment related health plans, other than those sponsored by governmental entities or churches – ask your employer about your 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 VIII. Miscellaneous Provisions

As a GHC Member, you will be able to select one of GHC's many neighborhood medical centers and will have access to the Cooperative's specialty centers and hospitals. In addition to choosing a medical center, you select your own personal family practice physician from the Cooperative's staff.

- **Identification Cards.** The Cooperative will furnish cards, for identification only, to all persons enrolled under the Group Medical Coverage Agreement.
- **Administration of Agreement.** The Cooperative may adopt reasonable policies and procedures to help in the administration of the Group Medical Coverage Agreement. Group Health Cooperative reserves the right to construe the provisions of this Medical Coverage Agreement, and to determine any and all questions pertaining to benefit entitlement and coverage.
- **Modification of Agreement.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Group Medical Coverage Agreement, convey or void any coverage, increase or reduce any benefit under the Group Medical Coverage Agreement or be used in the prosecution or defense of a claim under the Group Medical Coverage Agreement.

- **GHC Medicare.** For consumers enrolled under GHC's Medicare Plan, please contact GHC's Customer Service Department at 901-4600 or toll free within Washington at 1-888-901-4600 for a copy of the Medicare benefits portion of your coverage which is included in your employer's Group Medical Coverage Agreement with GHC.
Consumers enrolled under GHC's Medicare Plan will no longer be eligible for coverage through Group Health if they move outside GHC's Service Area.
- **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 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 to be performed by 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, or (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 that the disclosing party disclose Information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order. Each party shall maintain the confidentiality of medical records and confidential patient and employee Information as required by applicable law.*

Section IX. Enrollment Schedule

A. ENROLLMENT

1. **Application for Enrollment.** Application for enrollment shall be made on an application form furnished and approved by GHC. No person shall be enrolled or premiums accepted until this completed application has been received and approved by GHC. The Group is responsible for submitting completed application forms to GHC.

a. Special Enrollment Periods.

- Loss of Coverage. GHC will allow special enrollment periods for persons who (a) initially declined enrollment when newly eligible because such persons had another health care plan available through Group or other insurance coverage and have had such other coverage terminated due to cessation of employer contributions, exhaustion of COBRA continuation coverage, or loss of eligibility except for loss of eligibility for cause (GHC or Group may require that when initially offered coverage such persons submitted a written statement declining because of other coverage).—Application must be made within thirty-one (31) days of the termination of previous coverage or acquisition of a new dependent.*
- New Dependents. In the event a Subscriber or person eligible to be a Subscriber acquires a person eligible to be a Family Dependent by birth, marriage, adoption or placement for adoption, GHC will allow special enrollment periods for the person eligible to be a Subscriber, his or her spouse and the newly-acquired Family Dependent. Application must be made within thirty-one (31) days of acquisition of the new Family Dependent, except that sixty (60) days is permitted to enroll newborn and adopted children as described below.*

- Newly Eligible Persons.** Newly eligible Subscribers may make written application for enrollment to the Group within thirty-one (31) days of eligibility. If the Subscriber wishes to enroll his/her eligible Dependents, application must be made during this same thirty-one (31) day period.

Written application for enrollment for a newly dependent person, other than a newborn or newborn adopted child, must be made to the Group within thirty-one (31) days after the dependency occurs and will be subject to the Pre-existing Condition exclusion set forth in Section XI.A.

In the event there is a change in the monthly premiums payment as a result of the addition of a newborn child, the Subscriber must make written application for enrollment to the Group within sixty (60) days following the date of birth.

In the event there is a change in the monthly premiums payment as a result of the addition of an adoptive child, including adopted newborns, the Subscriber must make written application for enrollment within sixty (60) days from the day that the child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes financial responsibility for the medical expenses of the child.

When there is no change in the monthly premium payment, it is strongly advised that you enroll your newborn or newly adoptive child, including adopted newborns, as a dependent with your employer to avoid delays in payment of claims.

- c. **Open Enrollment.** A person not enrolled as a Subscriber or Family Dependent when newly eligible, as described above, may make written application during the Group's Open Enrollment period.
2. **Limitation on Enrollment.** This Agreement will be open for application as set forth in Section IX.A.1. Subject to prior approval by the Office of the Insurance Commissioner, GHC may limit enrollment, establish quotas, or set priorities for acceptance of new applications if it determines that its capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

B. PERSONS ENTITLED TO, OR ELIGIBLE TO PURCHASE MEDICARE.

For purposes of this section, an individual shall be deemed eligible for Medicare when he or she has the option to receive Part A Medicare benefits, irrespective of whether the individual elects to enroll in Part B coverage under the federal regulations.

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

Persons Residing Inside the Medicare+Choice Service Area. Except as defined by federal regulations (i.e., TEFRA), all Members who are eligible to purchase Medicare must **enroll in both Medicare Parts A and B and** transfer to the GHC Medicare Plan upon such eligibility **and enrollment**. A condition of coverage under the GHC Medicare Plan requires that a Member be continuously fully qualified and enrolled for the hospital (Part A) and medical (Part B) benefits, available from the Social Security Administration, and sign any papers that may be required by GHC or Medicare. All applicable provisions of the GHC Medicare Plan are fully set forth in the Medicare Endorsement(s) attached to this Agreement (if applicable).

Subscribers and covered dependents who are eligible for Medicare must, effective the date **TEFRA eligibility ends or the date** that Medicare would become the primary payor, enroll in Medicare Parts **A and B**, and must participate in GHC's Medicare plan. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under this group Agreement.

Persons Residing Outside the Medicare+Choice Service Area. Except as defined by federal regulations (i.e., TEFRA), all Members who are eligible to purchase Medicare must enroll in and maintain both Medicare Parts A and B. Failure to do so upon the effective date of Medicare eligibility will result in termination of coverage under this group Agreement.

- C. **PERSONS WHO ARE NOT ENTITLED TO, OR ELIGIBLE TO PURCHASE MEDICARE.** If a Member otherwise qualifies for Medicare but is not eligible to purchase Medicare, the Member may continue coverage under this Agreement upon payment of the applicable premiums as set forth in the Premiums Schedule.

Section X. Schedule Of Benefits

Subject to all provisions of this Group Medical Coverage Agreement, including, *without limitation, the accessing care provisions* the Allowances Schedule, and Exclusions, Members are entitled to receive the benefits and services that are Medically Necessary for the treatment of a Medical Condition as determined by GHC's Medical Director or his/her designee, and as described in this Schedule of Benefits.

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. As a cost-effective alternative in lieu of otherwise covered, Medically Necessary hospitalization or other covered, Medically Necessary institutional care, alternative care arrangements may be covered. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined appropriate and Medically Necessary based upon the patient's medical condition. Such determination of medical appropriateness and necessity, and authorization of coverage must be made in

advance by GHC. *Such care will be covered to the same extent that the replaced hospital care is covered as set forth in the Allowances Schedule.*

4. Drugs and medications which are *administered during confinement*.
5. Special duty nursing (when prescribed as Medically Necessary).
6. Maternity hospitalization and delivery.

If a Member is hospitalized in a ***non-GH Designated Facility or*** non-GH Facility, GHC reserves the right to require transfer of the Member to a GH ***or non-GH Designated 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 services are ***covered***, limited to the following:

1. Surgical services.
2. Diagnostic x-ray, nuclear medicine, ultrasound, and laboratory services.
3. Routine eye examinations and refractions are covered, limited to once every twelve (12) months, except when Medically Necessary. Services for routine eye examinations must be received at a GH Facility and in accordance with GHC medical criteria in order to be covered.

Evaluations and surgical procedures to correct refractions which are not related to eye pathology are not covered. Complications related to such surgery are also excluded.

Contact lens fittings and related examinations are not covered except as set forth below. Contact lens examinations and fittings for eye pathology are ***covered subject to the annual deductible and plan coinsurance***. When dispensed through GH Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery performed by a GHC Provider, provided the Member has been continuously covered by GHC since such surgery. Replacement of a covered contact lens will be provided only when needed due to change in the Member's medical condition but may be replaced only one time within any twelve (12) month period.

4. Family planning counseling services.
5. Hearing examinations to determine hearing loss.
6. Blood and blood derivatives and their administration.
7. 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, ***in accordance with Board of Health standards for screening and diagnostic tests during pregnancy***. Genetic testing of non-Members for the detection of congenital and heritable disorders is excluded.

Hospitalization and delivery, including home births for low risk pregnancies when approved in advance and provided by a GHC Provider, is covered. Birthing tubs are not covered. Voluntary (not medically indicated and non-therapeutic) or involuntary termination of pregnancy is covered. The Member's physician, in consultation with the mother, will determine the mother's length of inpatient stay following delivery. Pregnancy will not be considered a pre-existing condition exclusion under this Agreement. ***Treatment for post-partum depression or psychosis is covered only under the mental health benefit.***

8. Transplants. When authorized as medically appropriate by GHC's Medical Director or his/her designee, and in accordance with criteria established by the Cooperative, heart, heart-lung, single lung, double lung, kidney, simultaneous pancreas/kidney, cornea, bone marrow, and liver transplants. High dose chemotherapy and stem cell (obtained from the allogeneic or autologous peripheral blood or marrow as medically appropriate) support is covered when authorized as medically appropriate by GHC's Medical Director, or his/her designee. Transplant services are limited to the following:
 - a. evaluation testing to determine recipient candidacy;

- b. matching tests
- c. transplantation procedures as follows for inpatient and outpatient medical expenses. Covered procedures must be directly associated with, and occur at the time of, the transplant. Transplantation procedures are subject to the organ recipient's lifetime maximum as set forth in the Allowances Schedule.
 - hospital charges;
 - procurement center fees;
 - travel costs for a surgical team;
 - excision fees;
 - donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. GHC shall exclude coverage for donor costs to the extent that the donor costs are reimbursable by the organ donor's insurance.
- d. follow-up services for specialty visits,
- e. rehospitalization, and
- f. maintenance medications.

Exclusions

Transportation expenses, except as set forth under Section X.M. of this Agreement, and living expenses.

Coverage for all transplants and any related services, items, and drugs shall be excluded until such time as the Member has been continuously enrolled under this Agreement or any prior Medical Coverage Agreement provided by his or her current employer for twelve (12) consecutive months without any lapse in coverage immediately preceding and contiguous with enrollment under this Agreement.

This exclusion does not apply to children who have been continuously enrolled at GHC since birth, or if the Member requires a transplant as the result of a condition which had a sudden unexpected onset after the Member's effective date of coverage.

- 9. Visits by GHC Providers (including consultations and second opinions by a GHC Provider) in the hospital or office.
- 10. Preventive care (well care) services for health maintenance, including routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with criteria established by GHC for the detection of disease, and immunizations and vaccinations which are listed as covered in the GHC Drug Formulary (approved drug list). A fee may be charged for health education programs.

Services provided during a preventive care visit which are not in accordance with preventive care criteria are subject to the plan Coinsurance after the annual deductible is satisfied.

- 11. Radiation therapy services.
- 12. Medical and surgical services and related hospital charges, including orthognathic (jaw) surgery for the treatment of temporomandibular joint (TMJ) disorders, are covered as set forth in the Allowances Schedule when determined to be Medically Necessary and referred in advance by GHC. 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 orthopedic appliances (Section X.H.1.).

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

The following services including related hospitalizations, are excluded regardless of origin or cause:

- orthognathic (jaw) surgery in the absence of a TMJ diagnosis,
- treatment for cosmetic purposes, and
- all dental services (except as noted above), including orthodontic therapy.

13. The following services are covered by GHC when performed by a GHC Provider or GH oral surgeon: 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.
14. Medically Necessary implants, which are not experimental or investigational, are covered as determined by GHC's Medical Director, or his/her designee. Excluded are 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.
15. When authorized as medically appropriate by GHC's Medical Director, or his/her designee, and in accordance with criteria established by the Cooperative, treatment of growth disorders by growth hormones.

Growth hormone treatment shall be excluded until such time as the Member has been continuously enrolled under this Agreement or any prior GHC Medical Coverage Agreement for twelve (12) consecutive months without any lapse in coverage.

16. Respiratory therapy.
17. Dietary formula for the treatment of phenylketonuria (PKU) when determined Medically Necessary by GHC's Medical Director, or his/her designee. Coverage for this formula is not subject to a Pre-existing Conditions waiting period, if any.

Outpatient total parenteral nutritional therapy, when Medically Necessary and in accordance with medical criteria as established by GHC.

Outpatient elemental formulas for malabsorption are covered as set forth in the Allowances Schedule. Formulas for access problems are excluded. Equipment and supplies for the administration of enteral and parenteral therapy is covered under Devices, Equipment and Supplies.

Dietary formulas, oral nutritional supplements, special diets and prepared foods/meals, except treatment of phenylketonuria (PKU) and total parenteral and enteral nutritional therapy as set forth above, are excluded.

18. Self-referrals for manipulative therapy of the spine limited to one evaluation and ten (10) spinal manipulations only when provided by GHC Providers are covered as set forth in the Allowances Schedule. Additional visits ***are covered as set forth in the Allowances Schedule when approved by GHC.***

The medical necessity for manipulative therapy must meet GHC ***clinical criteria as Medically Necessary***. Excluded are services ***that do not meet GHC clinical criteria as Medically Necessary***, including, but not limited to, 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, or charges for office visits other than the initial evaluation.

19. Diabetic training and education.
20. Nontherapeutic sterilization procedures.
21. Detoxification services for alcoholism and drug abuse.

Coverage for acute chemical withdrawal is provided without prior approval. If a Member is hospitalized in a non-GH Designated Facility/***program***, coverage is subject to payment of the Deductible shown in the Allowances Schedule, and notification of GH by way of the GH 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-GH Designated Facility/***program***, GHC reserves the right to require transfer of the Member to a GH Facility/***program*** upon consultation with a GHP Provider. If the Member refuses transfer to a GH Facility/***program***, all further costs incurred during the hospitalization are the responsibility of the Member.

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

22. Circumcision.

23. General anesthesia services and related facility charges for dental procedures will be covered for Members under seven (7) years of age, physically or developmentally disabled persons, or for Members with a medical condition whose health would be put at risk if the dental procedure were performed in a dentist's office. Such services must be preauthorized and determined Medically Necessary by GHC, and performed at a GH or GH Designated hospital or ambulatory surgery facility.

GHC will not cover the dentist's or oral surgeon's fees.

24. *Bariatric surgery and related hospitalizations when GHC criteria are met. All other services required (e.g., prescribing and monitoring of drugs, structured weight loss and/or exercise programs, specialized nutritional counseling) are excluded.*

25. *Self-referrals for Covered Services provided by licensed acupuncturists and licensed naturopaths within their scope of licensure, when provided by GHC Providers, as set forth in the Allowances Schedule. Additional visits are covered as set forth in the Allowances Schedule when approved by GHC.*

Preventive care visits to acupuncturists and naturopaths are not covered. Herbal supplements are not covered. Laboratory services are covered only when provided at a Group Health operated or contracted laboratory.

26. Pre-existing Conditions are covered in the same manner as any other illness, except as provided under Section X.B.8. of this Agreement.

C. CHEMICAL DEPENDENCY TREATMENT

Subject to all terms and conditions of this Agreement, care is provided as set forth below at a GH Facility, GH Designated Facility, or GH-approved treatment program, subject to the Benefit Period Allowance as described below and as shown in the Allowances Schedule.

1. Chemical Dependency Treatment Services.

The GHC Medical Director or his/her designee shall make the final determination of the length and type of program and frequency of visits.

For chemical dependency treatment services, Medical Necessity is defined as those services necessary to treat a chemical dependency condition that is having a clinically significant impact on an individual's emotional, social, medical, and/or occupational functioning.

- a. All alcoholism and/or drug abuse treatment services must be: (1) provided at a facility as described above and must be authorized in advance, except for acute chemical withdrawal as described in Section X.B.; and (2) deemed Medically Necessary as defined above by GHC's Medical Director, or his/her designee. Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling, and prescription drugs and medicines (unless excluded under this Agreement).
- b. Court-ordered treatment shall be provided only if determined to be Medically Necessary by GHC's Medical Director or his/her designee.

2. Benefit Period and Benefit Period Allowance.

- a. **Benefit Period.** For the purpose of this section, "Benefit Period" shall mean a twenty-four (24) consecutive calendar month period during which the Member is eligible to receive covered chemical dependency treatment services as set forth in this section. The first Benefit Period shall begin on the first day the Member receives covered chemical dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under this Agreement remains in force. All subsequent Benefit Periods thereafter will begin on the first day Covered Services are received after expiration of the previous twenty-four (24) month Benefit Period.
- b. **Benefit Period Allowance.** The maximum allowance available for any Benefit Period shall be the total of all chemical dependency benefits provided and payments made for chemical dependency treatment, not to exceed the Benefit Period Allowance shown in the Allowances Schedule during the Member's Benefit Period.

Any Deductibles or Copayments which may be borne by the Member under the terms of this Agreement shall not be applied toward the Benefit Period Allowance.

D. PLASTIC AND RECONSTRUCTIVE SERVICES are covered:

1. to correct a congenital disease or congenital anomaly as determined by a GHC Provider; or
2. to correct a Medical Condition following an injury or incidental to 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.

In the case of a congenital condition which affects appearance, an anomaly will be considered to exist if the Member's appearance resulting from such condition is not within the range of normal human variation.

3. for reconstructive surgery and associated procedures following a mastectomy, regardless of when the mastectomy was performed. Internal breast prostheses required incident to the surgery will be provided.

A Member will be covered for all stages of reconstruction on the nondiseased breast to make it equivalent in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.

Complications of covered mastectomy services, including lymphedemas, are covered. Complications of noncovered surgical services are excluded.

E. HOME HEALTH CARE SERVICES, as set forth in this section, shall be provided by GHC Home Health Services or by a GH-authorized home health agency when 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 or 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; and
3. a GHC Provider has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

Covered Services for home health care may include the following when prescribed by a GHC Provider and when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy, and medical social worker and limited home health aide services. Home health services are provided 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 are: 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 are not specifically listed as covered under this Agreement.

F. HOSPICE

Members who elect to receive services from the GHC Hospice Program or GH-approved hospice program are entitled to hospice services as provided under the Hospice Program. Members who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period that they are in the hospice program. To receive hospice services, the Member is required to sign the Hospice Election Form.

It is understood and agreed that the following fully sets forth the eligibility requirements and Covered Services for a Member who elects to receive hospice services under the GHC Hospice Program.

GHC Hospice Program or GH-approved hospice program

1. **Eligibility.** Hospice Services, as set forth below, shall be provided to Members for as long as the following criteria are met:
 - a. A GHC Provider has determined that the Member's illness is terminal and life expectancy is six (6) months or less;

- b. the Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness);
- c. the Member has elected in writing to receive hospice care through GHC's Hospice Program or GH's approved hospice program;
- d. the Member has available a primary care person who will be responsible for the Member's home care; and
- e. a GHC Provider and GHC's Hospice Director, or his/her designee, determine that the Member's illness can be appropriately managed in the home.

2. **Hospice care** shall be defined as a coordinated program of palliative and supportive care for dying persons by an interdisciplinary team of professionals and volunteers centering primarily in the Member's home.

3. **Covered Services.** Hospice services 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 is defined as "skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill patient 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 provided 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 shall be provided in a facility designated by GHC's Hospice Program or GH-approved hospice program when Medically Necessary and authorized in advance by a GHC Provider and GHC's Hospice Program or GH-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 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. counseling services for the Member and his/her primary care-giver(s); and
- iv. bereavement counseling services for the family.

4. **Hospice Exclusions:** All services not specifically listed as covered in this section 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 this Medical Coverage Agreement.
- e. Any services provided by members of the patient's family.
- f. All other exclusions listed in Section XI., Exclusions of this Medical Coverage Agreement, apply.

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

- 1. All services must be provided at GHC or a GH-approved rehabilitation facility and must be prescribed and provided by a GH-approved rehabilitation team that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.
- 2. The Member must be referred for rehabilitation services in advance by a GHC Provider.

3. 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 one (1) above.
4. Coverage for inpatient and outpatient services is limited to the allowance set forth in the Allowances Schedule.

Services excluded under this benefit include the following: 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 governmental programs; 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 for neurodevelopmental therapies); recreational life-enhancing relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any other treatment not considered Medically Necessary by GHC; any services not specifically included as covered in this Section; and any services that are excluded under Section XI.

Neurodevelopmental Therapies for Children Age Six (6) and Under. When determined to be Medically Necessary by GHC's Medical Director, or his/her designee, 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.

Services excluded under this benefit include: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy, and speech therapy services when such services are available (whether application is made or not) through governmental programs; programs offered by public school districts; except as set forth above, therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning; implementation of home maintenance programs; any treatment not considered Medically Necessary; any services not specifically included as covered in this Section; and any services that are excluded under Section XI.

H. DEVICES, EQUIPMENT AND SUPPLIES

1. **Orthopedic Appliances.** When Medically Necessary, orthopedic appliances (commonly known as a brace or splint), which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function, are covered. Medically Necessary repair, adjustment or replacement of an orthopedic appliance is covered when authorized in advance by a GHC Provider. Covered Services are subject to the Coinsurance set forth in the Allowances Schedule. Excluded are arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; orthopedic shoes that are not attached to an appliance; or any orthopedic appliances that are not listed as covered in GHC's Orthopedic Appliance Formulary.
2. **Ostomy Supplies.** Medically Necessary ostomy supplies for the removal of bodily secretions or waste through an artificial opening are covered as set forth in the Allowances Schedule.
3. **Oxygen and Oxygen Equipment.** When medical criteria as established by GHC are met, and upon Referral, oxygen and oxygen equipment for home use is covered as set forth in the Allowances Schedule.
4. **Durable Medical Equipment** which is Medically Necessary, prescribed by a GHC Provider, in accordance with criteria established by GHC, and listed as covered in GHC's Durable Medical Equipment Formulary, limited to the following: rental (or purchase, if the cost of purchase is less than the anticipated total rental charges as determined solely by GHC) of hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps and other Durable Medical Equipment as specifically listed in GHC's Durable Medical Equipment Formulary. Services are covered as set forth in the Allowances Schedule.
5. **Prosthetic Devices.** Prosthetic devices (which are not orthopedic appliances), commonly known as an artificial limb, etc., which are listed as covered in the GHC Prosthetic Device Formulary when Medically Necessary and authorized in advance by a GHC Provider, as set forth in the Allowances Schedule.

Medically Necessary replacement or adjustment of these devices will be covered when authorized by a GHC Provider.

Excluded from coverage are replacements due to loss or damage.

Replacement or repair of appliances, devices and supplies that are due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference are excluded.

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

1. participation in one individual or group program per calendar year;
2. educational materials; and
3. one course of nicotine replacement therapy per calendar year, provided the Member is actively participating in the Group Health Free and Clear Program or GH-designated tobacco cessation program.

Covered Services are subject to the Allowances set forth in the Allowances Schedule.

J. LEGEND (PRESCRIPTION) DRUGS, MEDICINES, SUPPLIES AND DEVICES FOR OUTPATIENT USE as prescribed by a GHP Provider for conditions covered by this Agreement, 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), insulin, contraceptive drugs and devices and their fittings, insulin, diabetic supplies including insulin syringes, lancets, blood-glucose monitoring reagents and urine-testing reagents.

All drugs, supplies, medicines, and devices must be obtained at a GH pharmacy ***and, unless approved by GHC in advance, be listed in the GHC Drug Formulary (approved drug list)***. The prescription drug copayment as set forth in the Allowances Schedule applies to each 30-day supply. Copayments for single and multiple 30-day supplies of a given prescription are payable at the time of delivery. ***Drug Formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by Group Health.***

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. ***Generic drugs are 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. Brand name drugs are 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 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 are: over-the-counter drugs, medicines, ***supplies*** and devices not requiring a prescription under state law or regulations; dietary formulas and special diets, except as set forth in Section X.B.; contraceptive drugs and devices and their fitting unless otherwise noted in this section; 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 (approved drug list) unless ***approved in advance by GHC as Medically Necessary.***

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

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES.

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your Agreement. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact us at 206-901-4636 or 1-888-901-4636.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of this Agreement, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

K. MENTAL HEALTH CARE SERVICES. GHC and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this *Agreement* and to know the limitations on your coverage. If you would like a more detailed description than is provided here of covered benefits for mental health services under this *Agreement*, or if you have questions or concerns about any aspect of your mental health benefits, please contact GHC at 888-901-4636.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of the Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health provider, please call the State Health Department at 360-236-4902.

Services that are provided by a mental health practitioner, contracted or employed, to Members diagnosed as having a mental disorder that meet GHC's clinical necessity criteria for treatment, will be covered as mental health care, regardless of the cause of the disorder.

1. Outpatient Services. *Outpatient* mental health services provided *by or authorized under Referral from GHC Behavioral 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 the GHC Medical Director, or his/her designee.* *Treatment for clinical conditions may utilize psychiatric, psychological and psychotherapy services to achieve these objectives. GHC's Medical Director, or his/her designee, shall determine the length and type of treatment plan and/or program and the frequency of visits.*

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 X.B. and X.J. ***GHC clinics and contracted practitioner offices may have office policies that determine how missed appointments will be managed. Payment for charges of missed appointments are the responsibility of the Member.***

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

When authorized in advance by GHC's Medical Director, or his/her designee, partial hospitalization and outpatient electro-convulsive therapy *treatments* are covered subject to the maximum inpatient benefit limit described in the Allowances Schedule. Every two (2) partial hospitalization days or two (2) electro-convulsive therapy treatments are equivalent to one inpatient hospital day. The total maximum annual benefit under this section shall not exceed the number of inpatient days described in the Allowances Schedule.

Subject to the maximum Inpatient Mental Health Care Allowance as set forth in the Allowances Schedule, services provided under involuntary commitment statutes shall be covered at facilities approved by GHC. Services for any *involuntary* court-ordered treatment program beyond the 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 as set forth in Section X.L., including the twenty-four (24) hour notification and transfer provisions. All other voluntary psychiatric care must be authorized in advance by the Director of GHC's *Behavioral Health* Service, or his/her designee; the facility must be approved by the Cooperative. All voluntary care not authorized in advance by GHC's *Behavioral Health* Service is not covered.

3. Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services. Covered Services are limited to those considered to be Medically Necessary by GHC's Medical Director, or his/her designee. Covered Services are limited to those provided for covered *clinical* conditions for which, in the opinion of GHC's Medical Director, or his/her designee, *reduction or removal of acute clinical symptoms* or stabilization can be expected.

Partial hospitalization programs and electro-convulsive therapy are covered only under subsection K.2. (Inpatient Services).

Excluded *from Behavioral Health coverage* are all forms of day treatment (*non-partial hospital programs*) and custodial care. *Treatment specific to and solely for personality disorders, learning, communication and motor skills disorders, mental retardation, academic or career counseling, are not covered under Behavioral Health coverage. Treatment specific to and solely for sexual and identity disorders, personal growth or relationship enhancement are not covered.* Specialty programs for mental health therapy which are not *specifically authorized* by *Behavioral Health Services and approved by* GHC; court-ordered treatment which is not specifically described above; or any other services not specifically listed as covered in this section. All other provisions, exclusions and limitations under this Agreement also apply.

L. EMERGENCY/URGENT CARE

Emergency Care (See Section I. for a definition of Emergency):

1. **At a GH Facility or GH Designated Facility.** GHC will cover Emergency care for all Covered Services as set forth in the Allowances Schedule.
2. **At a Non-GH Designated Facility.** Usual, Customary, and Reasonable charges for Emergency care for Covered Services are covered subject to:
 - a. payment of the Emergency Care Deductible shown in the Allowances Schedule; and
 - b. notification of GH by way of the GH Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

Outpatient medications prescribed by a non-GHC Provider are excluded.

3. Waiver of Emergency Care Copayment/Deductible.

- a. **Waiver for Multiple Injury Accident.** If two or more members of the Family Unit require Emergency care as a result of the same accident, only one Emergency Care Copayment/Deductible will apply.
 - b. **Emergencies Resulting in an Inpatient Admission.** If the Member is admitted to a GH or GH Designated Facility directly from the emergency room, the Emergency Care Copayment is waived. However, the first day's Hospital Care Copayment, if any, will be charged.
4. **Transfer and Follow-up Care.** If a Member is hospitalized in a non-GH Facility, GHC reserves the right to require transfer of the Member to a GH Facility *or GH Designated Facility*, upon consultation between a GHC Provider and the attending physician. If the Member refuses to transfer to a GH Facility *or GH Designated 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 in advance.

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

5. **Urgent Care.** Care for Urgent Conditions received inside the GHC Service Area is covered only at GH medical centers, GH urgent care clinics, or network providers' offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider.

M. 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 I.)

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

N. SKILLED NURSING FACILITY care in a GH-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending GHC Provider, as set forth in the Allowances Schedule.

When prescribed by a GHC Provider, such care may include board and room; 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 from coverage are personal comfort items such as telephone and television; and rest cures, custodial, domiciliary or convalescent care.

Section XI. Exclusions

In addition to exclusions listed in the previous sections, the following are excluded:

1. Except as specifically listed and identified as covered in Sections X.B., X.D., X.H., and X.J., corrective appliances and artificial aids including: eyeglasses; contact lenses, including services related to their fitting; prosthetic devices; hearing **devices, hearing** aids and examinations in connection therewith; take-home dressings and supplies following hospitalization; or any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section X.
2. Cosmetic services, including treatment for complications of cosmetic surgery, except as provided in Section X.D.
3. Convalescent or custodial care.
4. Durable medical equipment such as hospital beds, wheelchairs, and walk-aids, except while in the hospital or as set forth in Section X.B. or X.H.
5. Services rendered as a result of work-**related** injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.
6. Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel, or insurance purposes that are not deemed Medically Necessary by GHC for early detection of disease.
7. Experimental or investigational services.
 - (a) A service is experimental or investigational for a Member's condition if any of the following statements apply to it as of the time the service is or will be provided to the Member. The service (i) 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; or (ii) is the subject of a current new drug or new device application on file with the FDA; or (iii) 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; or (iv) 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; or (v) is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services; or (vi) 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; or As to the service: (vii) the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the 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, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.
 - (c) GHC consults with GHC's Medical Director and then uses the criteria described above to decide if a particular service is experimental or investigational.

Appeals regarding denial of coverage must be submitted to your regional Member Services Department, or west of the Cascade mountains to GHC's Appeals Department at the Administration and Operations Campus, PO Box 34593, Seattle WA 98124-1593, or east of the Cascade mountains to GH's Patient Relations Department at 5615 West Sunset Highway,

Spokane, WA 99224. GHC will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if delay would jeopardize the Member's life or health.

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. Regardless of origin or cause, diagnostic testing and medical treatment of sterility, infertility, and sexual dysfunction, including artificial insemination for any reason, unless otherwise noted in Section X.B.
10. Any services to the extent benefits are available to the Member 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: (1) medical coverage, medical "no fault" coverage, Personal Injury Protection coverage, or similar medical coverage contained in said policy; and/or (2) uninsured motorist or underinsured motorist 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, is a third-party donee beneficiary under the terms of the policy, or otherwise has the right to receive benefits under the policy.

The Member and his or her agents must cooperate fully with GHC in its efforts to enforce this exclusion. This cooperation shall include supplying GHC with information about any available insurance coverage. The Member and his or her agents 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 or her agents shall do nothing to prejudice GHC's right to enforce this exclusion. In the event the Member fails to cooperate fully, the Member shall be responsible for reimbursing GHC for such medical expenses.

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

GHC shall not pay any attorneys' fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHC prior to any collection efforts. ***Under no circumstances will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHC. If it becomes necessary for GHC to enforce the provisions of this section by initiating any action against the injured person or his or her agent, then the injured person agrees to pay GHC's attorneys' fees and costs associated with the action.***

11. Services or supplies not specifically listed as covered in the Schedule of Benefits.
12. Voluntary (not medically indicated and nontherapeutic) termination of pregnancy, unless otherwise noted in Section X.B.7.
13. The cost of services and supplies resulting from a Member's loss of or willful damage to covered appliances, devices, supplies, and materials provided by GHC for the treatment of disease, injury, or illness.
14. Orthoptic (eye training) therapy.
15. Specialty treatment programs such as weight reduction, rehabilitation (***including cardiac rehabilitation***), and "behavior modification programs."
16. Nontherapeutic sterilization (unless otherwise noted in Section X.B.) and procedures and services to reverse a therapeutic or nontherapeutic sterilization.
17. Dental care, surgery, services, and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery, and any other dental services not specifically listed as covered in Section X. The Cooperative'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. All drugs and medicines for outpatient use, except as specified in Section X.J. Any exclusion of drugs, medicines, and injections, including those not listed as covered in the GHC Drug Formulary (approved drug list), will also exclude their administration.
19. Mental health care, except as specifically provided in Section X.K.
20. Hypnotherapy, and all services related to hypnotherapy.

21. Genetic testing and related services are excluded unless determined Medically Necessary by GHC's Medical Director, or his/her designee, ***in accordance with Board of Health standards for screening and diagnostic tests***, or specifically provided in Section X.B. Testing for non-Members is also excluded.
22. Follow-up visits related to a non-Covered Service.
23. Services required as a result of war, whether declared or not declared. Care needed for injuries or conditions resulting from active or reserve military service.
24. Missed appointment or cancellation fees.
25. ***Routine ultrasound to determine fetal age, size or sex.***
26. ***Routine foot care except in the presence of a non-related Medical Condition affecting the lower limbs.***
27. ***Complications of non-Covered Services.***
28. ***Treatment of obesity, except as set forth in Section X.B.***

Section XII. Claims

Claims for benefits may be made before or after services are obtained. To make a claim for benefits under this 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 Covered Services, the Member must, within sixty (60) days of the service date, or as soon thereafter as is reasonably possible, either a) contact GHC Customer Service to make a claim or b) pay the bill and submit a claim for reimbursement of Covered Services to GHC. If the Member is located west of the Cascade mountains, submit claims ***for reimbursement*** to PO Box 34585, Seattle, WA 98124-1585; if the Member is located east of the Cascade mountains submit claims to PO Box 200, Spokane, WA 99210-0200. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the service date.

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

- ***Pre-service claims – within 15 days, or an extension of up to 15 days will be requested***
- ***Claims involving urgently needed care – within 72 hours***
- ***Concurrent care claims – within 24 hours***
- ***Post-service claims – within 30 days, or an extension of up to 15 days will be requested.***

In some circumstances, timeframes may be extended if GHC requests additional information.

EMPLOYER GROUP PROGRAMS

GROUP MEDICARE COVERAGE

This brief outline describes the benefits available to you when you combine your employer group healthcare benefits with Medicare. ALL MEDICARE GUIDELINES AND CRITERIA MUST BE MET.

BENEFITS

INPATIENT HOSPITAL (Medical/Surgical)

- Covered up to 365 days per year.

SKILLED NURSING FACILITY

- Group benefit or up to 100 days per benefit period after a 3 day hospital stay.

INPATIENT MENTAL HEALTH

- Group benefit or up to 190 days per lifetime benefit covered in full in a Medicare-certified psychiatric hospital.

INPATIENT ALCOHOLISM & DRUG ABUSE TREATMENT

- Covered in full when such services are provided in a hospital-based treatment center.

HOME HEALTH CARE (SUCH AS PART-TIME SKILLED NURSING CARE, PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY)

- Covered in full, in accordance with Medicare guidelines.
-

MEDICAL CARE:

- Physician care in a hospital and home covered in full.
- Office and outpatient hospital care covered, subject to applicable copayment.
- Alcoholism and substance abuse treatment services covered in full.

AMBULANCE

- Covered in full

CARDIAC REHABILITATION

- Covered subject to the applicable copayment

CHIROPRACTIC & PODIATRIC CARE (Medical Need)

- Covered, subject to the applicable copayment.

EMERGENCY AND OUT-OF-AREA URGENTLY NEEDED SERVICES

- You pay \$50 for each hospital emergency room visit; you do not pay this amount if you are admitted directly to the hospital from the emergency room.

- Worldwide coverage is provided.

HEARING EXAMINATIONS & HEARING AIDS

- Hearing exams to determine hearing loss are covered, subject to the applicable copayment. Purchase of hearing aids covered once every 24 months limited to \$250 hearing aid purchase allowance. Please see your Certificate of Coverage for more information.

HEALTH/WEELLNESS EDUCATION

- Health club services (SilverSneakers®) and/or lifetime fitness programs at participating network health clubs are covered in full.
- Services related to tobacco cessation and education materials are covered in full, limited to:
 1. One individual or group program per calendar year.
 2. When participating in a GH Tobacco Cessation program, your employer group covers one course of nicotine replacement or other approved pharmacy products once per calendar year. Your employer group outpatient prescription drug copayment applies.

ORGAN TRANSPLANT

- Medicare covered organ transplants covered in full.

OUTPATIENT MENTAL HEALTH CARE

- Covered, subject to the applicable copayment.

OUTPATIENT PRESCRIPTION DRUGS

- Medicare covered outpatient prescription drugs are covered in full. Your employer group may cover outpatient prescription drugs. Please see the employer group section of this Certificate of Coverage for more information.

POINT-OF-SERVICE (POS)

- Non-emergent and/or non-urgently needed care received while temporarily traveling outside GH's Medicare Service Area is payable at Medicare benefit levels up to \$2,000 per member per calendar year. The Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services **ONLY**. The enrollee is responsible for all Medicare deductibles.

PHYSICAL, OCCUPATIONAL, SPEECH AND LANGUAGE THERAPY

- Covered subject to the applicable copayment

PROSTHETIC DEVICES, PACEMAKERS, BRACES, ARTIFICIAL LIMBS & EYES

- Covered in full.

RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

- Covered in full.

URGENTLY NEEDED SERVICES

- Urgently needed services are covered, subject to applicable copayment.
- Worldwide coverage is provided.

VISION CARE (Eye Care Medical Need)

- Examinations for illness and injury covered in full, subject to the applicable copayment.
- One pair of eyeglasses or contact lenses are covered after each cataract surgery with insertion of an intraocular lens (IOL).
- Routine eye exams for glasses covered subject to the applicable copayment once every 24 months.
- One pair of standard vision, lenticular, or non-blended bifocal or trifocal lenses, or contact lenses will be covered subject to the GH-approved allowance once every twenty-four (24) months.

Please see your employer group Certificate of Coverage for more information.

Please contact our Group Health Customer Service Center for more information and the location of participating reciprocal facilities at 206-901-4636, toll-free 1-888-901-4636, or TTY/TDD 711 or 1-800-833-6388 for the “hearing impaired,” Monday-Friday, 7:30 a.m. to 5:00 p.m.

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