Group Health Options, Inc.

2016 Benefits Booklet
Options HSA

CA-2563a16,
WCIF HSA

Important Notice Under Federal Health Care Reform

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

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

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

Women's health and cancer rights

If the Member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Member will also receive coverage for:

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

These services will be provided in consultation with the Member and the attending physician and will be subject to the same Cost Shares otherwise applicable under the Benefits Booklet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Carriers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For More Information

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

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I. Introduction

Note: This is a Health Savings Account (HSA) Qualified Health Plan. The health plan meets all of the requirements to be used in conjunction with a Member-initiated Health Savings Account. The provisions of the Benefits Booklet do not override, or take the place of, any regulatory requirements for Health Savings Accounts. Participation in a health savings account is not a requirement for enrollment or continued eligibility. Group Health is not a trustee, administrator or fiduciary of any Health Savings Account which may be used in conjunction with the Benefits Booklet. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

This Benefits Booklet is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between Group Health Options, Inc. ("Group Health") and the Group. The benefits were approved by the Group who contracts with Group Health for health care coverage. This Benefits Booklet is not the Group medical coverage agreement itself. In the event of a conflict between the Group medical coverage agreement and the benefits booklet, the benefits booklet language will govern.

The provisions of the Benefits Booklet must be considered together to fully understand the benefits available under the Benefits Booklet. Words with special meaning are capitalized and are defined in Section XII.

Contact Group Health Customer Service at 206-901-4636 or toll-free 1-888-901-4636 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

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

- Care provided by Group Health's Options Network, referred to as "Network".
- Care provided by a Community Provider. Coverage provided by a Community Provider is limited to the Allowed Amount. See the Definitions Section XII. for more information on these providers.
  - Out-of-Country providers are limited to Emergency services and urgent care only when provided by a provider who meets licensing and certification requirements established where the provider practices.

Members may choose either option at any time during or for differing episodes of illness or injury, except during an inpatient admission.

Benefits paid under one option will not be duplicated under the other option.

The level of benefits available for services received at the Network is generally greater than the level of benefits available for services received from Community Providers. In order for services to be covered at the higher benefit level, services must be obtained from Network Providers at Network Facilities, except for Emergency services and care pursuant to a Preauthorization. Emergency services will always be covered at the Network level.

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

2. Primary Care Provider Services.

Group Health recommends that Members select a Network Personal Physician when enrolling. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member. For information on how to select or change personal physicians, and for a list of participating personal physicians, call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington at 1-888-901-4636 or by accessing the Group Health website at www.ghc.org. The change will be made within 24 hours of the receipt of the request if the selected

physician's caseload permits. If a personal physician accepting new Members is not available in your area, contact the Group Health Customer Service Center, who will ensure you have access to a personal physician by contacting a physician's office to request they accept new Members.

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

3. **Specialty Care Provider Services.**
Unless otherwise indicated in Section II. or Section IV., Preauthorization is required for in the Network specialty care and specialists that are not Group Health-designated Specialists and are not providing care at facilities owned and operated by Group Health.

Group Health-designated Specialist.
Members may make appointments with Group Health-designated Specialists at facilities owned and operated by Group Health without Preauthorization. To access a Group Health-designated Specialist, consult your Group Health personal physician, contact Customer Service for a list of Group-Health-designated Specialists, or view the Provider Directory located at www.ghc.org. The following specialty care areas are available from Group Health-designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services and urology.

4. **Hospital Services.**
Non-Emergency inpatient hospital services require Preauthorization. Refer to Section IV. for more information about hospital services.

5. **Emergency Services.**
Members must notify Group Health by way of the Group Health Hospital notification line (1-888-457-9516 as noted on your member identification card) within 24 hours of any admission, or as soon thereafter as medically possible. Refer to Section IV. for more information about Emergency services.

6. **Urgent Care.**
Under the Network option, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Under the Community Provider option, urgent care is covered at any medical facility. Refer to Section IV. for more information about urgent care.

7. **Women's Health Care Direct Access Providers.**
Female Members may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Within the Network, women's health care services are covered as if the Member's Personal Physician had been consulted, subject to any applicable Cost Shares. Women's health care services obtained from a Community Provider are covered at the Community Provider benefit level. If the Member's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Member or her chosen provider must obtain Preauthorization in accordance with applicable Group Health requirements.

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

First Level Review:

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

Second Level (Practitioner) Review:

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

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

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

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

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

F. Preauthorization.
Covered Services may require Preauthorization. Refer to Section IV. for more information. Group Health recommends that the provider requests Preauthorization for Community Provider services as reflected in Section IV. Members may also contact Customer Service. Preauthorization requests are reviewed and approved based on Medical Necessity, eligibility and benefits.

G. Recommended Treatment.

Group Health's medical director will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment will be made in good faith. Members have the right to appeal coverage decisions (see Section VIII). Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended services to the extent permitted by law. Members who obtain care not recommended by Group Health's medical director do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care.

H. Second Opinions.

The Member may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member may request Preauthorization or may visit a Group Health-designated Specialist for a second opinion. When requested or indicated, second opinions are provided by Network Providers and are covered with Preauthorization, or when obtained from a Group Health-designated Specialist. The Member may also obtain a second opinion from a Community Provider without Preauthorization, subject to Community Provider Cost Shares and all other Preauthorization requirements specifically stated within Section IV. Coverage is determined by the Member's Benefits Booklet; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Preauthorization for a second opinion does not imply that Group Health will authorize the Member to return to the physician providing the second opinion for any additional treatment. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the Benefits Booklet.

I. Unusual Circumstances.

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

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

Under the Community Provider option, if Covered Services are delayed or unavailable due to unusual circumstances such as those described above, Group Health shall have no liability or obligation to arrange for Covered Services.

J. Utilization Management.

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

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

III. Financial Responsibilities

A. Premium.

The Subscriber is liable for payment to the Group of his/her contribution toward the monthly premium, if any.

B. Financial Responsibilities for Covered Services.

Note: Various Cost Shares may or may not be eligible for determining the Member's annual Health Savings Account contribution limit. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

The Subscriber is liable for payment of the following Cost Shares for Covered Services provided to the Subscriber and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. **Annual Deductible.**
   Note: Covered Services may be subject to an annual Deductible. The annual Deductible amount a Member must pay is determined by whether the Member is a sole Subscriber or has enrolled Dependents**.**

   a. **Subscriber Only Coverage (individual coverage).**
      Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the annual Deductible is met.

   b. **Family Coverage (coverage for the Subscriber plus one (1) or more Dependents).**
      Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the total family annual Deductible is met. The total family annual Deductible can be met by one member or by all family members in combination. Until the total family annual Deductible is met, benefits will not be provided for any family member.

2. **Plan Coinsurance.**
   After the applicable annual Deductible is satisfied, Members may be required to pay Plan Coinsurance for Covered Services. Coinsurance is calculated on the Allowed Amount.

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

4. **Out-of-pocket Limit.**
   Note: The Member's Out-of-pocket Limit is determined by whether the Member is a sole Subscriber or has enrolled Dependents.

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

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

IV. Benefits Details

Benefits are subject to all provisions of the Benefits Booklet. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by Group Health's medical director and as described herein. All Covered Services are subject to case management and utilization management at the discretion of Group Health. "Case management" means a care management plan developed for a Member whose diagnosis requires timely coordination.

Under the Community Provider option, Members shall be required to pay any difference between the Community Provider's charge for services and the Allowed Amount.

	Network	**Community Provider**
Annual Deductible	Subscriber pays $1,500 per calendar year for Subscriber only coverage Member pays $3,000 per Family Unit per calendar year for family coverage Until the total family annual Deductible is met, benefits will not be provided for any family member	Shared with Network
Coinsurance	**Plan Coinsurance:** Member pays 20% of the Allowed Amount	**Plan Coinsurance:** Member pays 40% of the Allowed Amount
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits	
Out-of-pocket Limit	Limited to a maximum of $3,500 per calendar year for Subscriber only coverage Limited to a maximum of $6,850 per Family Unit per calendar year for family coverage Out-of-Pocket Limit is determined by whether the Member is a sole Subscriber or has enrolled Dependents	Shared with Network
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services	**The following Out-of-pocket Expenses apply to the Out-of-pocket Limit:** All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period	

Acupuncture	Network	Community Provider
Acupuncture needle treatment. Under the Network option, limited to 8 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. No visit limit for treatment for Chemical Dependency. Under the Network option, laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Herbal supplements; reflexology; any services not within the scope of the practitioner's licensure		

Allergy Services	Network	Community Provider
Allergy testing.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Allergy serum and injections.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Ambulance	Network	Community Provider
Emergency ground or air transport to any facility.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Under the Network option, non-Emergency ground or air interfacility transfer requires Preauthorization. Under the Network option, non-Emergency ground or air interfacility transfer to or from a Network Facility when initiated by Group Health.	After Deductible, Member pays 20% Plan Coinsurance **Hospital-to-hospital ground transfers:** After Deductible, Member pays nothing	After Deductible, Member pays 40% Plan Coinsurance

Cancer Screening and Diagnostic Services	Network	Community Provider
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service. See Preventive Services for additional information.	No charge; Member pays nothing	No charge; Member pays nothing **Routine Mammography:** No charge; Member pays nothing

Diagnostic laboratory and diagnostic services for cancer. See Diagnostic Laboratory and Radiology Services for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Chemical Dependency	**Network**	**Community Provider**
Chemical dependency services including inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V. Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted. For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning. Chemical dependency services must be provided at a Group Health-approved treatment facility or treatment program. Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79). Non-Washington State alcoholism and/or drug abuse treatment service providers must meet the equivalent licensing and certification requirements established in the state where the provider's practice is located. Contact Customer Service for additional information on Non-Washington State providers. Court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary. Residential Treatment and non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "Acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Member for whom consequences of abstinence are so severe that they	**Emergency Services:** After Deductible, Member pays 20% Plan Coinsurance	**Emergency Services:** After Network Deductible, Member pays 20% Plan

require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health. Coverage for acute chemical withdrawal (detoxification) is provided without Preauthorization. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Group Health reserves the right to require transfer of the Member to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Member refuses transfer to a Network Facility/program, all services received will be covered under the Community Provider option.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance	Coinsurance **Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatments programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State		

Circumcision	**Network**	**Community Provider**
Circumcision. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance

Clinical Trials	**Network**	**Community Provider**
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal and state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible,	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible,

	Member pays 20% Plan Coinsurance	Member pays 40% Plan Coinsurance
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis		

Dental Services and Dental Anesthesia	**Network**	**Community Provider**
Dental services including accidental injury to natural teeth.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
General anesthesia services and related facility charges for dental procedures for Members who are under 7 years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office. Under the Network option, general anesthesia services for dental procedures require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Dentist's or oral surgeon's fees; dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery; any other dental service not specifically listed as covered		

Devices, Equipment and Supplies (for home use)	**Network**	**Community Provider**
• Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Member's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. Group Health will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6	After Deductible, Member pays 50% coinsurance	After Deductible, Member pays 50% coinsurance

months. Replacements within this 6 month period are covered when Medically Necessary due to a change in the Member's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting. Under the Network option, devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.		
Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's home or personal vehicle		

Diabetic Education, Equipment and Pharmacy Supplies	Network	Community Provider
Diabetic education and training.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 50% coinsurance	After Deductible, Member pays 50% coinsurance
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	**Certain preventive medications as determined by Group Health:** No charge; Member pays nothing **Preferred generic drugs (Tier 1):** After Deductible, Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $30 Copayment **Non-Preferred generic**	**Preferred generic drugs (Tier 1):** After Deductible, Member pays $20 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $35 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $55 Copayment

	and brand name drugs (Tier 3): After Deductible, Member pays $50 Copayment	
Diabetic retinal screening.	No charge, Member pays nothing	After Deductible, Member pays 40% Plan Coinsurance

Dialysis (Home and Outpatient)	**Network**	**Community Provider**
Dialysis in an outpatient or home setting is covered for Members with end-stage renal disease (ESRD). Under the Network option, dialysis requires Preauthorization.	**Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Injections administered by a professional in a clinical setting during dialysis.	**Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Certain preventive medications as determined by Group Health:** No charge; Member pays nothing **Preferred generic drugs (Tier 1):** After Deductible, Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $50 Copayment	**Preferred generic drugs (Tier 1):** After Deductible, Member pays $20 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $35 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $55 Copayment

Drugs - Outpatient Prescription	**Network**	**Community Provider**
Prescription drugs, supplies and devices for a supply of 30	**Certain preventive**	**Preferred generic**

days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), mental health drugs, self-administered injectables, and routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. All drugs, supplies and devices must be obtained at a Group Health-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the Group Health Service Area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory, or can be obtained by contacting the Group Health Customer Service Center. Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services when obtained with a prescription. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.ghc.org.	**medications as determined by Group Health:** No charge; Member pays nothing **Preferred generic drugs (Tier 1):** After Deductible, Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $50 Copayment	**drugs (Tier 1):** After Deductible, Member pays $20 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $35 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $55 Copayment
Injections administered by a professional in a clinical setting.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Over-the-counter drugs not included under Preventive Care.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the Group Health-designated mail order service.	Member pays the prescription drug Cost Share for each 30 day supply or less	Not covered; Member pays 100% of all charges

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

Members may request a coverage determination by contacting Customer Service. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits.

Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of

FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Generic drugs are dispensed whenever available. A generic drug is a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when a Member tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions, incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If a Member has a new prescription for a chronic condition, the Member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.

The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact Group Health at 206-901-4636 or toll-free 1-888-901-4636 or by accessing the Group Health website at www.ghc.org.

Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Benefits Booklet, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.

Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.

Exclusions: Over-the-counter drugs, supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	Network	Community Provider
Emergency Services. See Section XII. for a definition of Emergency. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. If a Member is admitted as an inpatient directly from a Network Facility emergency department, any Emergency services Copayment is waived. Coverage is subject to the Network hospital services Cost Share. If a Member is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility upon consultation between a Network Provider and the attending physician. If the Member refuses to transfer to a Network Facility or does not notify Group Health within 24 hours following admission, all services received will be subject to the Community Provider hospital services Cost Share. Under the Network option, follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is received. Under the Community Provider option, follow-up care which is a direct result of the Emergency is covered subject to the Community Provider Cost Shares.	After Deductible, Member pays 20% Plan Coinsurance	After Network Deductible, Member pays 20% Plan Coinsurance

Hearing Examinations and Hearing Aids	Network	Community Provider
Cochlear implants when in accordance with Group Health clinical criteria. Covered services for cochlear implants include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at Group Health-approved facilities.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance

Hearing aids including hearing aid examinations.	Not covered; Member pays 100% of all charges	Not covered; Member pays 100% of all charges
Exclusions: Programs or treatments for hearing loss or hearing care including, but not limited to, externally worn hearing aids or surgically implanted hearing aids and the surgery and services necessary to implant them other than for cochlear implants; hearing screening tests required under Preventive Services		

Home Health Care	**Network**	**Community Provider**
Home health care when the following criteria are met: • The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Member requires intermittent skilled home health care, as described below. • Group Health's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a Group Health-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment; medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider. Under the Community Provider option, home health care must be prescribed by a provider and provided by a State-licensed home health agency. Under the Network option, home health care requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Private duty nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above		

Hospice	**Network**	**Community Provider**
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the Member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. **Inpatient Hospice Services.** Under the Network option, for short-term care, inpatient hospice services are covered with Preauthorization. Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member for a maximum of 5 consecutive days per occurrence. **Other covered hospice services, when billed by a licensed hospice program, may include the following:** • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment when billed by a licensed hospice care program. Under the Network option, hospice care requires Preauthorization.		
Exclusions: Private duty nursing, financial or legal counseling services; meal services; any services provided by family members		

Hospital - Inpatient and Outpatient	Network	Community Provider
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). Outpatient hospital includes ambulatory surgical centers. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance

institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization. Members receiving the following nonscheduled inpatient services are required to notify Group Health by way of the Group Health Hospital notification line within 24 hours following any admission, or as soon thereafter as medically possible: acute chemical withdrawal (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained. Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services. Non-Emergency inpatient hospital services require Preauthorization.		
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that have not been approved by Group Health's medical director		

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

Infusion Therapy	**Network**	**Community Provider**
Medically Necessary infusion therapy includes, but is not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Associated infused medications.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Laboratory and Radiology	Network	Community Provider
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Customer Service for any questions regarding these services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Manipulative Therapy	Network	Community Provider
Manipulative therapy of the spine and extremities when in accordance with Group Health clinical criteria, limited to a combined total of 20 visits per calendar year.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Member; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet Group Health clinical criteria as Medically Necessary		

Maternity and Pregnancy	Network	Community Provider
Maternity care and pregnancy services, including care for complications of pregnancy, in utero treatment for the fetus and prenatal and postpartum care are covered for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth and prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by Group Health's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery and associated Hospital Care, including home births and birthing centers. Home births are considered outpatient services.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance

Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery.		
Termination of pregnancy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications		

Mental Health	**Network**	**Community Provider**
Mental health services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by Group Health's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health services including medical management and prescriptions are covered the same as for any other condition. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required. ABA therapy requires Preauthorization. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by Group Health's medical director. Services provided under involuntary commitment statutes are covered only at Group Health-approved facilities. Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency services	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance

benefit. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. Inpatient mental health services must be provided at a hospital or facility that Group Health has approved specifically for the treatment of mental or nervous disorders. Non-Emergency inpatient hospital services require Preauthorization.		
Exclusions: Academic or career counseling; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating not considered Medically Necessary; specialty treatment programs such as "behavior modification programs" not considered Medically Necessary; relationship counseling or phase of life problems (V code only diagnoses); custodial care		

Naturopathy	**Network**	**Community Provider**
Naturopathy. Under the Network option, limited to 3 visits per medical diagnosis per calendar year without Preauthorization. Additional visits are covered with Preauthorization. Under the Network option, laboratory and radiology services are covered only when obtained through a Network Facility.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure		

Newborn Services	**Network**	**Community Provider**
Newborn services are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother. Preventive services for newborns are covered under	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance

Preventive Services. See Section VI.A.3. for information about temporary coverage for newborns.	**Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance

Nutritional Counseling	**Network**	**Community Provider**
Nutritional counseling. Services related to a healthy diet to prevent obesity are covered as Preventive Services.	After Deductible, Member pays 20% Plan Coinsurance	Not covered; Member pays 100% of all charges
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs; pre and post bariatric surgery nutritional counseling		

Nutritional Therapy	**Network**	**Community Provider**
Dietary formula for the treatment of phenylketonuria (PKU).	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Enteral therapy (elemental formulas) for malabsorption and an eosinophilic gastrointestinal disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements; special diets; prepared foods/meals		

Obesity Related Services	**Network**	**Community Provider**
Services directly related to obesity, including bariatric surgery. Preventive services related to obesity screening and counseling are covered as Preventive Services.	**Hospital - Inpatient:** Not covered; Member pays 100% of all charges **Hospital - Outpatient:** Not covered; Member	**Hospital - Inpatient:** Not covered; Member pays 100% of all charges **Hospital - Outpatient:** Not covered; Member

	pays 100% of all charges **Outpatient Services:** Not covered; Member pays 100% of all charges	pays 100% of all charges **Outpatient Services:** Not covered; Member pays 100% of all charges
Exclusions: Obesity treatment and treatment for morbid obesity for any reason, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, except as described above; specialty treatment programs such as weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig or other such programs; medications and related physician visits for medication monitoring; pre and post bariatric surgical nutritional counseling		

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

Oncology	Network	Community Provider
Radiation therapy, chemotherapy, oral chemotherapy.	**Radiation Therapy and Chemotherapy:** After Deductible, Member pays 20% Plan Coinsurance **Oral Chemotherapy Drugs:** **Certain preventive medications as determined by Group Health:** No charge; Member pays nothing **Preferred generic drugs (Tier 1):** After Deductible, Member pays $15 Copayment **Preferred brand name**	**Radiation Therapy and Chemotherapy:** After Deductible, Member pays 40% Plan Coinsurance **Oral Chemotherapy Drugs:** **Preferred generic drugs (Tier 1):** After Deductible, Member pays $20 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $35 Copayment **Non-Preferred generic and brand name drugs**

	drugs (Tier 2): After Deductible, Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $50 Copayment	**(Tier 3):** After Deductible, Member pays $55 Copayment

Optical (vision)	Network	Community Provider
Routine eye examinations and refractions, limited to once every 12 months. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions, as often as Medically Necessary.	**Routine Exams:** After Deductible, Member pays 20% Plan Coinsurance **Exams for Eye Pathology:** After Deductible, Member pays 20% Plan Coinsurance	**Routine Exams:** Not covered; Member pays 100% of all charges **Exams for Eye Pathology:** After Deductible, Member pays 40% Plan Coinsurance
Contact lenses for eye pathology. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by Group Health since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription.	**Frames and Lenses:** Not covered; Member pays 100% of all charges **Contact Lenses for Eye Pathology:** After Deductible, Member pays 20% Plan Coinsurance	**Frames and Lenses:** Not covered; Member pays 100% of all charges **Contact Lenses for Eye Pathology:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Eyeglasses; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures		

Oral Surgery	Network	Community Provider
Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. Group Health's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services. Under the Network option, oral surgery requires	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance

Preauthorization.	**Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature		

Outpatient Services	**Network**	**Community Provider**
Covered outpatient medical and surgical services in a provider's office, including chronic disease management. See Preventive Services for additional information related to chronic disease management. See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance

Plastic and Reconstructive Surgery	**Network**	**Community Provider**
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of Group Health's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. Under the Network option, inpatient and outpatient hospital plastic and reconstructive surgery require Preauthorization. Under the Community Provider option, inpatient hospital plastic and reconstructive surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services		

Podiatry	**Network**	**Community Provider**
Medically Necessary foot care.	After Deductible, Member pays 20% Plan	After Deductible, Member pays 40% Plan

Routine foot care covered when such care is directly related to the treatment of diabetes and other clinical conditions that effect sensation and circulation to the feet.	Coinsurance	Coinsurance
Exclusions: All other routine foot care		

Preventive Services	**Network**	**Community Provider**
Preventive services in accordance with the well care schedule established by Group Health. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF). Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; FDA-approved contraceptive drugs, devices, including device removal, and counseling; preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription; pap smears; routine mammography screening; routine prostate screening; colorectal cancer screening for Members who are age 50 or older or who are under age 50 and at high risk; obesity screening/counseling; healthy diet; and physical activity counseling. Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the Group Health well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	No charge; Member pays nothing	No charge; Member pays nothing **Routine Mammography:** No charge; Member pays nothing

Exclusions: Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes that are not deemed Medically Necessary by Group Health for early detection of disease; all other diagnostic services not otherwise stated above

Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy, pulmonary and cardiac rehabilitation) and Neurodevelopmental Therapy	**Network**	**Community Provider**
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist. Habilitative care, including: occupational therapy, physical therapy, speech therapy is covered when prescribed by a physician. Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Member's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. Limited to a combined total of 60 inpatient days and 60 outpatient visits per calendar year for all Rehabilitation, Habilitative care and Neurodevelopmental Therapy services. Non-Emergency inpatient hospital services and Network massage therapy require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Specialty treatment programs; inpatient Residential Treatment services; specialty rehabilitation programs including "behavior modification programs"; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning (except as described for neurodevelopmental therapy); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs		

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

Skilled Nursing Facility	Network	Community Provider
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a combined total of 60 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care		

Sterilization	Network	Community Provider
Female sterilization procedures. See Preventive Services for additional information. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** No charge; Member pays nothing	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** No charge; Member pays nothing
Vasectomy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Procedures and services to reverse a sterilization		

Telehealth	Network	Community Provider
Telehealth (audio and video communication) services	**Hospital - Outpatient:**	**Hospital - Outpatient:**

between a consulting distant site provider, and the originating site provider, where the Member is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.	After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services; the site fee from the originating location		

Temporomandibular Joint (TMJ)	**Network**	**Community Provider**
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
TMJ appliances. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays 50% coinsurance	After Deductible, Member pays 50% coinsurance
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea; hospitalizations related to these exclusions		

Tobacco Cessation	**Network**	**Community Provider**
Individual/group counseling and educational materials.	No charge; Member pays nothing	After Deductible, Member pays 40% Plan Coinsurance
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	No charge; Member pays nothing **Other approved pharmacy products: Certain preventive medications as determined by Group Health:** No charge;	**Preferred generic drugs (Tier 1):** After Deductible, Member pays $20 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $35 Copayment

	Member pays nothing **Preferred generic drugs (Tier 1):** After Deductible, Member pays $15 Copayment **Preferred brand name drugs (Tier 2):** After Deductible, Member pays $30 Copayment **Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $50 Copayment	**Non-Preferred generic and brand name drugs (Tier 3):** After Deductible, Member pays $55 Copayment

Transgender Services	Network	Community Provider
Medically Necessary medical and surgical services for gender reassignment. Prescription drugs are covered the same as for any other condition (see Drugs - Outpatient Prescription for coverage). Counseling services are covered the same as for any other condition (see Mental Health for coverage). Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 20% Plan Coinsurance	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:** After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services; travel		

Transplants	Network	Community Provider
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and	**Hospital - Inpatient:** After Deductible, Member pays 20% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 20% Plan Coinsurance **Outpatient Services:**	**Hospital - Inpatient:** After Deductible, Member pays 40% Plan Coinsurance **Hospital - Outpatient:** After Deductible, Member pays 40% Plan Coinsurance **Outpatient Services:**

excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits. • Rehospitalization. • Maintenance medications during an inpatient stay. Transplant services require Preauthorization.	After Deductible, Member pays 20% Plan Coinsurance	After Deductible, Member pays 40% Plan Coinsurance
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; transportation expenses except as covered as Ambulance Services		

Urgent Care	**Network**	**Community Provider**
Under the Network option, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Under the Community Provider option, urgent care is covered at any medical facility. See Section XII. for a definition of Urgent Condition.	**Emergency Department:** After Deductible, Member pays 20% Plan Coinsurance **Urgent Care Center:** After Deductible, Member pays 20% Plan Coinsurance **Provider's Office:** After Deductible, Member pays 20% Plan Coinsurance	**Emergency Department:** After Network Deductible, Member pays 20% Plan Coinsurance **Urgent Care Center:** After Deductible, Member pays 40% Plan Coinsurance **Provider's Office:** After Deductible, Member pays 40% Plan Coinsurance

V. General Exclusions

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

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the Benefits Booklet, except as required by federal or state law.

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

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

4. Convalescent Care.

5. Services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.

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

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

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

9. Experimental or investigational services.

   Group Health consults with Group Health's medical director and then uses the criteria described below to decide if a particular service is experimental or investigational.

   a. A service is considered experimental or investigational for a Member's condition if any of the following statements apply to it at the time the service is or will be provided to the Member:
      1) The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted.
      2) The service is the subject of a current new drug or new device application on file with the FDA.
      3) The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial.
      4) The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy as among its objectives.
      5) The service is under continued scientific testing and research concerning the safety, toxicity or efficacy of services.
      6) The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity or efficacy.
      7) The prevailing opinion among experts, as expressed in the published authoritative medical or scientific literature, is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity or efficacy of the service.

   b. The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
      1) The Member's medical records.
      2) The written protocol(s) or other document(s) pursuant to which the service has been or will be provided.
      3) Any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service.
      4) The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body.
      5) The published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury.
      6) Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

   Appeals regarding Group Health denial of coverage can be submitted to the Member Appeal Department, or to Group Health's medical director at P.O. Box 34593, Seattle, WA 98124-1593.

10. Hypnotherapy and all services related to hypnotherapy.

11. Directed umbilical cord blood donations.

12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non-Members.

13. Autopsy and associated expenses.

VI. Eligibility, Enrollment and Termination

Note: If a Subscriber enrolls any eligible Dependent(s), the family level annual Deductible must be met before any benefits will be provided and the family level Out-of-pocket Maximum will apply.

A. Eligibility.

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

1. Subscribers.

Bona fide employees as established and enforced by the Group shall be eligible for enrollment. Please contact the Group for more information.

2. Dependents.

The Subscriber may also enroll the following:

a. The Subscriber's legal spouse.

b. The Subscriber’s state-registered domestic partner (as required by Washington state law) or if specifically included as eligible by the Group, the Subscriber’s non-state registered domestic partner.

c. Children who are under the age of 26.

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

Eligibility may be extended past the Dependent’s limiting age as set forth above if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred prior to attainment of the limiting age, 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 Group Health upon request, but not more frequently than annually after the 2 year period following the Dependent's attainment of the limiting age.

3. Temporary Coverage for Newborns.

When a Member gives birth, the newborn is entitled to the benefits set forth in the Benefits Booklet from birth through 3 weeks of age. All provisions, limitations and exclusions will apply except Subsections F. and G. After 3 weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled.

B. Application for Enrollment.

Application for enrollment must be made on an application approved by Group Health. The Group is responsible for submitting completed applications to Group Health.

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

1. **Newly Eligible Subscribers.**
   Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within 31 days of becoming eligible.

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

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

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

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

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

4. **Special Enrollment.**

   a. Group Health will allow special enrollment for persons:
      1) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
         - Cessation of employer contributions.
         - Exhaustion of COBRA continuation coverage.
         - Loss of eligibility, except for loss of eligibility for cause.
      2) Who initially declined enrollment when otherwise eligible because such persons had other health care coverage and who have had such other coverage exhausted because such person reached a lifetime maximum limit.

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

   b. Group Health will allow special enrollment for individuals who are eligible to be a Subscriber and his/her Dependents in the event one of the following occurs:
      1) Marriage. Application for coverage must be made within 31 days of the date of marriage.
      2) Birth. Application for coverage for the Subscriber and Dependents other than the newborn child must be made within 60 days of the date of birth.
      3) Adoption or placement for adoption. Application for coverage for the Subscriber and Dependents other than the adopted child must be made within 60 days of the adoption or placement for adoption.
      4) Eligibility for premium assistance from Medicaid or a state Children's Health Insurance Program (CHIP), provided such person is otherwise eligible for coverage under this Benefits Booklet. The

request for special enrollment must be made within 60 days of eligibility for such premium assistance.

5) Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP.
6) Applicable federal or state law or regulation otherwise provides for special enrollment.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- Enrollment for a newly eligible Subscriber and listed Dependents is effective on the date eligibility requirements are met, provided the Subscriber's application has been submitted to and approved by Group Health. Please contact the Group for more information.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the date eligibility requirements are met. Please contact the Group for more information.
- 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 or the Subscriber assumes total or partial financial support of the child.

2. Commencement of Benefits for Persons Hospitalized on Effective Date.

Members who are admitted to an inpatient facility prior to their enrollment will receive covered benefits beginning on their effective date, as set forth in Subsection C.1. above. If a Member is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a Network Facility, all services received will be subject to Community Provider Cost Shares.

D. Eligibility for Medicare.

Note: Eligibility for Medicare may affect the tax deductibility of Health Savings Account contributions. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

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

A Member who is enrolled in Medicare has the option of continuing coverage under this Benefits Booklet while on Medicare coverage. Coverage between this Benefits Booklet and Medicare will be coordinated as outlined in Section IX.

E. Termination of Coverage.

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

Termination of Specific Members.

Individual Member coverage may be terminated for any of the following reasons:

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

b. For Cause. In the event of termination for cause, Group Health reserves the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses or other damages. Coverage of a Member may be terminated upon 10 working days written notice for:
   1.) Material misrepresentation, fraud or omission of information in order to obtain coverage.
   2.) Permitting the use of a Group Health identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

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

Individual Member coverage may be retroactively terminated upon 30 days written notice and only in the case of fraud or intentional misrepresentation of a material fact; or as otherwise allowed under applicable law or regulation. Notwithstanding the foregoing, Group Health reserves the right to retroactively terminate coverage for nonpayment of premiums or contributions by the Group as described above.

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

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

F. Continuation of Inpatient Services.

A Member who is receiving Covered Services in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

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

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

G. Continuation of Coverage Options.

1. Continuation Option.

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

2. Leave of Absence.

While on a Group approved leave of absence, the Subscriber and listed Dependents can continue to be covered provided that:

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

- The Group continues to remit premiums for the Subscriber and Dependents to Group Health.

3. **Self-Payments During Labor Disputes.**
In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage 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 6 months after the cessation of work.

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

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

4. **Continuation Coverage Under Federal Law.**
This section applies only to Groups who must offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or the Uniformed Services Employment and Reemployment Rights Act (USERRA) and only applies to grant continuation of coverage rights to the extent required by federal law. USERRA only applies in certain situations to employees who are leaving employment to serve in the United States Armed Forces.

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

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

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

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

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

VII. Grievances

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

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

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

Step 3: If the Member is still not satisfied, he/she should call Customer Service at 206-901-4636 or toll-free 1-888-901-4636. Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. An appropriate representative will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Member's written statement.

If the Member is dissatisfied with the resolution of the complaint, he/she may contact Customer Service. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

VIII. Appeals

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the Group Health medical director. The appeals process is available for a Member to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan. Group Health will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting Group Health's Member Appeal Department at the address or telephone number below.

1. Initial Appeal

If the Member or the Member's legal representative wishes to appeal a Group Health decision to deny, modify, reduce or terminate coverage of or payment for health care services, he/she must submit a request for an appeal either orally or in writing to Group Health's Member Appeal Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Group Health will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to Group Health's Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, toll-free 1-866-458-5479.

A party not involved in the initial coverage determination and not a subordinate of the party making the initial coverage determination will review the appeal request. Group Health will then notify the Member of its determination or need for an extension of time within 14 days of receiving the request for appeal. Under no circumstances will the review timeframe exceed 30 days without the Member's written permission.

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

There is an **expedited/urgent appeals process** in place for cases which meet criteria or where delay using the standard appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited/urgent appeal in writing to the above address, or by calling Group Health's Member Appeal Department toll-free 1-866-458-5479. The nature of the patient's condition will be evaluated by a physician and if the request is not accepted as urgent, the member will be notified in writing of the decision not to expedite and given a description on how to grieve the decision. If the request is made by the treating physician who believes the member's condition meets the definition of expedited, the request will be processed as expedited.

The request for an expedited/urgent appeal will be processed and a decision issued no later than 72 hours after receipt of the request.

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

If the Member requests an appeal of a Group Health decision denying benefits for care currently being received, Group Health will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the Group Health determination stands, the Member may be responsible for the cost of coverage received during the review period.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or at toll-free 1-800-562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/.

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

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

IX. Claims

Claims for benefits may be made before or after services are obtained. Group Health recommends that the provider requests Preauthorization. In most instances, contracted providers submit claims directly to Group Health. If your provider does not submit a claim to make a claim for benefits, a Member must contact Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

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

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

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

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

X. Coordination of Benefits

Note: If a Member participating in a Health Savings Account has other health care coverage, the tax deductibility of Health Savings Account contributions may be affected. Please contact the Health Savings Account trustee or administrator regarding questions about requirements for Health Savings Accounts.

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

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

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

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

Definitions.

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

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

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

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

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

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

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

D. Allowable Expense. Allowable expense is a health care expense, coinsurance or copayments and without reduction for any applicable deductible, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense.

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

2. If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

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

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

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

Order of Benefit Determination Rules.

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

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

B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

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

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

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

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

2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
   b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
      ii. If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
      iii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
      iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subsection (a) above determine the order of benefits; or
      v. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The plan covering the custodial parent, first;
         - The plan covering the spouse of the custodial parent, second;
         - The plan covering the non-custodial parent, third; and then
         - The plan covering the spouse of the non-custodial parent, last.

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

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

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

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

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

Effect on the Benefits of this Plan.

When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Member be responsible for a deductible amount greater than the highest of the two deductibles.

Right to Receive and Release Needed Information.

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

Facility of Payment.

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

Right of Recovery.

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

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

Effect of Medicare.

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

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

When a Member, who is a Medicare beneficiary and for whom Medicare has been determined to be the primary bill payer under Medicare secondary payer guidelines and regulations, seeks care from Community Providers, Group Health has no obligation to provide any benefits except as specifically outlined in the Community Provider option under Section IV.

XI. Subrogation and Reimbursement Rights

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

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

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

Group Health’s subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages.

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, Group Health’s Medical Expenses are secondary, not primary.

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

The Injured Person and his/her agents shall do nothing to prejudice Group Health's subrogation and reimbursement rights. The Injured Person shall promptly notify Group Health of any tentative settlement with a third party and shall not settle a claim without protecting Group Health's interest. If the Injured Person fails to cooperate fully with Group Health in recovery of Group Health's Medical Expenses, the Injured Person shall be responsible for directly reimbursing Group Health for 100% of Group Health's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until Group Health's subrogation and reimbursement rights are fully determined and that Group Health has an equitable lien over such monies to the full extent of Group Health's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of Group Health's Medical Expenses.

If this Benefits Booklet is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of Group Health, under special circumstances, the Injured Person may request and Group Health may agree to reduce the amount of reimbursement to Group Health by an amount for reasonable and necessary attorney's fees and costs incurred by the Injured Person on behalf of and for the benefit of Group Health, but only if such amount is agreed to in writing by Group Health prior to settlement or recovery.

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

XII. Definitions

Allowance	The maximum amount payable by Group Health for certain Covered Services.
Allowed Amount	A term used to define the level of benefits which are payable by Group Health. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between the Community Provider's charge for services and the Allowed Amount.
Benefits Booklet	The Benefits Booklet is a statement of benefits, exclusions and other provisions as set forth in the Group medical coverage agreement between Group Health and the Group.
Community Provider	Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.79 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, podiatrists licensed under 18.22 RCW or, in the case of non-Washington State providers or out-of-country providers, those providers meeting equivalent licensing and certification requirements established in the territories where the provider's practice is located. For purposes of the Benefits Booklet, Community Providers do not include individuals employed by or under contract with Group Health's Network or who provide a service or treat Members outside the scope of their licenses.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.

Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.
Covered Services	The services for which a Member is entitled to coverage in the Benefits Booklet.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under Group Health's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of a Subscriber's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health, or if the Member is pregnant, the health of her unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Family Unit	A Subscriber and all his/her Dependents.
Group	An employer, union, welfare trust or bona-fide association which has entered into a Group medical coverage agreement with Group Health.
Group Health-designated Specialist	A specialist specifically identified by Group Health.
Health Savings Account (HSA)	A tax-exempt savings account established exclusively for the purpose of paying qualified medical expenses and meeting other requirements under federal law.
Health Savings Account (HSA) Qualified Health Plan	A high deductible health plan that meets regulatory requirements for use in conjunction with a Health Savings Account.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
Medical Condition	A disease, illness or injury.

Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by Group Health's medical director according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, his/her family or the provider of the services or supplies; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under Group Health's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by Group Health's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Member	Any enrolled Subscriber or Dependent.
Network Facility	A facility (hospital, medical center or health care center) owned, operated or otherwise designated by Group Health's Network.
Network Personal Physician	A provider who is employed by or contracted with Group Health's Network to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-Emergency Covered Services, except for services set forth in the Benefits Booklet which a Member can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Group Health's Network and any other health care professional or provider with whom the Network has contracted to provide health care services to Members, including, but not limited to, physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of health care services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington. The participating provider for this Benefits Booklet is Group Health Cooperative.
Out-of-pocket Expenses	Those Cost Shares paid by the Subscriber or Member for Covered Services which are applied to the Out-of-pocket Limit.

Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Subscriber and his/her Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Member is required to pay for Covered Services received.
Preauthorization	An approval by Group Health that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the Benefits Booklet. Members who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah.
Subscriber	A person employed by or belonging to the Group who meets all applicable eligibility requirements, is enrolled and for whom the premium has been paid.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.