
GROUP HEALTH COOPERATIVE

VALUE PLAN

FOR ACTIVE PEBB EMPLOYEES

FOR BENEFITS AVAILABLE BEGINNING JANUARY 1, 2009

Certificate of Coverage

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

Please Read And Save This Document You Are Responsible For Understanding Your Benefits

This book is your Certificate of Coverage with GHC, and explains benefits specific to your health plan. This Certificate of Coverage supersedes all previous certificates. If there are inconsistencies with federal or state statute or rules, the statute or rule will have precedence.

A full description of benefits, exclusions, limits and Out-of-Pocket Expenses can be found in the Benefit Details, Page 14; Benefit Exclusions and Limitations, Page 32; and Allowances Schedule, Page 8. These sections must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized. They are defined in Terms Used in this Booklet, Page 3.

Important Phone Numbers

Consulting Nurse:	
Western WA	1-800-297-6877
Eastern WA	1-800-826-3620
Customer Service	1-888-901-4636
TTY WA Relay	1-800-833-6388
Emergency Notification Line:	1-888-457-9516

Visit Our Web Site for PEBB Employees at www.ghc.org/pebb

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Terms Used in This Booklet

Agreement: The PEBB benefit plan.

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

Allowed Charge: Allowed charge means one of the following:

Contracting Providers: The allowed charge is the amount agreed upon between GHC and the provider for Medically Necessary Covered Services.

Providers who have contracts with GHC agree not to bill Enrollees for any charges above the amount agreed upon by GHC and the provider, except for any Deductibles, Coinsurance, Copayments, amounts in excess of stated benefit maximums and charges for noncovered services for which the Enrollee is responsible.

Non-Contracting Providers: The Usual, Customary and Reasonable (UCR) charges made by providers for Medically Necessary services covered under this Agreement.

Except for emergency care inside the Service Area or Emergency or urgent care outside the Service Area, services received from non GHC Providers without a Referral authorized by GHC are not covered.

Annual Deductible. A deductible is a specific amount the Enrollee is required to pay for certain covered services before benefits are payable under this Agreement. Charges subject to the annual Deductible shall be borne by the Enrollee during each calendar year until the annual Deductible is met. There is an individual annual Deductible amount for each Enrollee and a maximum aggregate annual Deductible amount for each family. Once the aggregate annual Deductible amount is reached for a family in a calendar year, the individual annual Deductibles are also deemed reached for each Enrollee during that same calendar year.

Charges applied toward the individual annual Deductible during the months of October, November and December are also applied in an equal amount toward the Enrollee's annual Deductible for the next calendar year. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate family deductible does not carry over into the next calendar year.

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

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

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

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

Covered Services: The services for which an Enrollee is entitled to coverage under the Agreement.

Custodial/Convalescent Care: Care that is designed primarily to assist the Enrollee in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervision of medications that are ordinarily self-administered. GHC reserves the right to determine which services constitute custodial or convalescent care.

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

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 Enrollee's health in serious jeopardy.

Enrollee: Any subscriber or dependent enrolled under the Agreement.

Experimental or Investigational Services:

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

service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

- b) In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively: (i) the Enrollee's medical records, (ii) the written protocol(s) or other document(s) pursuant to which the service has been or will be provided, (iii) any consent document(s) the Enrollee or Enrollee's representative has executed or will be asked to execute, to receive the service, (iv) the files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body, (v) the published authoritative medical or scientific literature regarding the service, as applied to the Enrollee's illness or injury, and (vi) regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.
- c) Appeals regarding denial of coverage can be submitted to the Member Appeals Department, or to GHC's Medical Director at P.O. Box 34593, Seattle, WA 98124-1593. GHC will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Enrollee's life or health.

Family Planning Services: Those medical care services related to planning the birth of children through the use of birth control methods, including elective sterilization.

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

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

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

GHC Personal Physician: A provider who is employed by or contracted with GHC to provide primary care services to Enrollees and is selected by each Enrollee to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which an Enrollee can access without a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Enrollee.

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

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

Medical Condition: A disease, illness or injury.

Medically Necessary: Appropriate and clinically necessary services, if recommended by the Enrollee's treating provider and by GHC's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to an Enrollee 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 Enrollee, 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 Enrollee; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under GHC's schedule for preventive services; (d) are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Enrollee'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 Enrollee's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not Experimental or Investigational Services. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by GHC's Medical Director, or his/her designee. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a covered service as described in the "Benefit Details" section of this booklet and not excluded from coverage. The cost of non-covered services and supplies shall be the responsibility of the Enrollee.

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

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

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

Proof of Continuous Coverage: The Certificate of Creditable Coverage provided to the Enrollee by the Enrollee's prior health plan; or a letter from the Enrollee's employer, on the employer's letterhead, providing the time period the Enrollee and/or dependent(s) of the Enrollee were covered by health insurance.

Referral: A written temporary agreement requested in advance by a GHC Provider and approved by GHC that entitles an Enrollee to receive Covered Services from a specified

health care provider. Entitlement to such services shall not exceed the limits of the Referral and is subject to all terms and conditions of the Referral and the Agreement. Enrollees who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services.

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

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

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

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

ALLOWANCES SCHEDULE

Benefits will be provided at the payment levels specified below and in the benefits section of this booklet up to the benefit maximum limits. The services below correspond with the benefit descriptions in the following section, "Benefit Details." Please read the "Benefit Details" and "What's Not Covered" sections for specific benefit limitations, maximums, and exclusions.

Payment Summary

Annual Deductible	\$100 per person or \$300 per family. Annual Deductible applies to all services unless otherwise indicated.
Out-of-Pocket Limit	Copayments and Coinsurance paid by an Enrollee for Covered Services throughout the calendar year shall not be more than \$1,500 per person or \$3,000 per family . Except as noted below, the Out-of-Pocket Limit applies to combined expenses for all inpatient hospital admissions; outpatient services; ambulance services; and emergency care at a GHC or non-GHC Facility covered under the Agreement. The following will not accumulate toward the annual Out-of-Pocket Limit: prescription drug Copayments, durable medical equipment Coinsurance, annual Deductible, charges beyond the benefit maximums, and charges for noncovered services.
Maximum Plan Payment	None.

Covered Service	Benefit
1. Accidental Injury to Teeth	100% subject to \$15 Copayment per visit
2. Ambulance Services Air Ambulance Ground Ambulance	100% subject to \$100 Copayment 100% subject to \$75 Copayment
3. Ambulatory Surgical Center	100% subject to \$150 Copayment
4. Blood and Blood Derivatives	100%
5. Chemical Dependency Treatment \$14,500 per 24 consecutive calendar month period Inpatient Outpatient Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year 100% subject to \$15 Copayment per visit
6. Diabetic Education	100% subject to \$15 Copayment per visit
7. Diagnostic X-ray, Nuclear Medicine and Laboratory Services	100% (for Preventive Care see provision 24)
8. Dialysis	100% subject to \$15 Copayment per visit
9. Durable Medical Equipment and Supplies (for home use) and Prostheses When provided in a home health setting in lieu of hospitalization as described in Home Health, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for DME provided in a hospice setting.	80% Not subject to the annual Deductible. 20% Coinsurance does not apply to annual Out-of-Pocket Limit
10. Emergency/Urgent Care Emergency Care (Copayment waived if admitted directly from emergency room) Urgent Care	100% subject to \$75 Copayment per visit Not subject to the annual Deductible 100% subject to \$15 Copayment per visit
11. Hearing Examinations and Hearing Aids Routine Exam Hearing Aids	100% subject to \$15 Copayment per exam 100%; maximum of \$800 every 36 months Hearing aids are not subject to the annual Deductible
12. Home Health	100% Not subject to the annual Deductible

Covered Service	Benefit
13. Hospice Care Respite Care	100% 100% of 5 days maximum per 3 month period of hospice care
14. Hospital Services Inpatient facility services Inpatient professional services Outpatient surgery facility services Outpatient surgery professional services	100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year 100% 100% subject to \$150 Copayment 100%
15. Mental Health Care Inpatient Outpatient - 50 visits per calendar year	100% subject to \$200 Copayment per day; \$600 maximum per person per calendar year 100% subject to \$15 Copayment per visit
16. Neurodevelopmental Therapy For Children Age 6 and Younger Inpatient - 60 days per calendar year Outpatient - 60 visits per calendar year for all therapies combined	100% subject to \$200 Copayment per day; \$600 maximum per person per calendar year 100% subject to \$15 Copayment per visit
17. Nutritional Services Phenylketonuria (PKU) supplements Enteral therapy (formula) Parenteral therapy (total parenteral nutrition)	100% when provided for the disorder 80% for elemental formulas 100% for parenteral formulas
18. Obstetric and Newborn Care Inpatient facility services Professional inpatient and outpatient services	100% subject to \$200 Copayment per day; maximum \$600 per calendar year 100%

Covered Service	Benefit
<p>19. Office and Clinic Visits</p> <p>Acupuncture</p> <p>Naturopathy</p>	<p>100% subject to \$15 Copayment per visit</p> <p>100% subject to \$15 Copayment for Self-Referrals to a GHC Provider up to a maximum of eight (8) visits per Enrollee per medical diagnosis per calendar year. When approved by GHC, additional visits are covered</p> <p>100% subject to \$15 Copayment for Self-Referrals to a GHC Provider up to a maximum of three (3) visits per Enrollee per medical diagnosis per calendar year. When approved by GHC, additional visits are covered</p>
<p>20. Organ Transplants</p> <p>Inpatient facility services</p> <p>Inpatient professional services</p>	<p>100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year</p> <p>100%</p>
<p>21. Physical, Occupational, Speech and Massage Therapies (Rehabilitation Services)</p> <p>Inpatient - 60 days per year</p> <p>Outpatient - 60 visits per calendar year for all therapies combined</p>	<p>100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year</p> <p>100% subject to \$15 Copayment per visit</p>
<p>22. Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)</p>	<p>Payment levels are determined by the service provided</p>

Covered Service	Benefit
<p>23. Prescription Drugs, Insulin and Diabetic Supplies Retail - Up to a 30 day supply</p> <p>Formulary generic drugs, all disposable diabetic supplies and all insulin.</p> <p>Formulary brand-name drugs</p> <p>Mail-Order - Up to 90-day supply</p> <p>Formulary generic drugs, all disposable diabetic supplies and all insulin.</p> <p>Formulary brand-name drugs</p>	<p>100% subject to \$10 Copayment per prescription or refill</p> <p>100% subject to \$30 Copayment per prescription or refill</p> <p>100% subject to \$20 Copayment per prescription or refill</p> <p>100% subject to \$60 Copayment per prescription or refill</p> <p>Not subject to the annual Deductible Copayments do not apply to annual Out-of-Pocket Limit.</p>
<p>24. Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms and prostate/colorectal cancer screening)</p> <p>Eye refractions are not included under preventive care (see Vision Care)</p> <p>Physicals for travel, employment, insurance or license are not covered (see General Exclusions)</p>	<p>100%</p> <p>Not subject to the annual Deductible</p>
<p>25. Radiation and Chemotherapy Services</p>	<p>100%</p>
<p>26. Skilled Nursing Facility (SNF); 150 days per calendar year</p>	<p>100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year</p>
<p>27. Spinal Manipulations Self-referred manipulative therapy of the spine and extremities in accordance with GHC clinical criteria up to a maximum of ten (10) visits per Enrollee per calendar year</p>	<p>100% subject to \$15 Copayment per visit</p>
<p>28. Temporomandibular Joint Dysfunction (TMJ) (Medical)</p>	<p>50% to \$1,000 per calendar year</p>

Covered Service	Benefit
29. Tobacco Cessation Services Individual/group sessions Approved pharmacy products	100% 100% when prescribed as part of the GHC-designated tobacco cessation program Not subject to the annual Deductible
30. Vision Care (Routine) Routine eye exams: one exam every twelve (12) consecutive months Hardware each 2 calendar years: either lenses and frames, or contact lenses	100% subject to \$15 Copayment per exam 100% to \$150 maximum Hardware is not subject to the annual Deductible.
31. Weight Control Bariatric surgery (preauthorization required)	100% subject to \$200 Copayment per day; maximum \$600 per person per calendar year

Benefit Details

All benefits are subject to the exclusions, limitations, and eligibility provisions contained in this booklet. GHC provides services through all types of health care providers licensed under state law. Benefits are payable for preventive care and Medically Necessary Services that are provided by GHC Providers or obtained in accordance with Referral or authorization requirements, except for Emergency care or as provided under coordination of benefits provisions. Authorization and Referral requirements are described in the "Preauthorization and Referral Procedures" section of this booklet. Services received after termination of PEBB coverage, will not be covered. Except when required by law, the Enrollee will be liable for any services provided after termination of PEBB coverage.

Services that are provided by mental health service providers to Enrollees diagnosed as having a mental disorder will be covered as Mental Health Care, regardless of the cause of the disorder.

1. ACCIDENTAL INJURY TO TEETH

The services of a licensed dentist will be covered subject to a \$15 office visit Copayment for repair of accidental injury to natural teeth, after the annual Deductible is satisfied. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified. Services and supplies for the following are not covered: Injuries caused by biting or chewing; malocclusion resulting from an accidental injury; orthodontic treatment; dental implants; conditions not directly resulting from the accident; and treatment not completed within the time period established in the written treatment plan.

2. AMBULANCE SERVICES

Emergency ground ambulance services are subject to a \$75 Copayment per trip to a GHC Facility, or the nearest facility where care is available, after the annual Deductible is satisfied. If ground ambulance services are not appropriate for transporting the Enrollee to the nearest facility, the plan covers emergency air ambulance subject to a \$100 Copayment per trip, after the annual Deductible is satisfied. The service must meet the definition of an Emergency and be considered the only appropriate method of transportation, based solely on medical necessity.

If GHC approves an Enrollee's transfer from one facility to another, the ambulance transportation Copayment will not apply.

3. AMBULATORY SURGICAL CENTER

Services at an ambulatory surgery center (discharged within 24 hours of admission) are covered subject to a \$150 facility Copayment per surgery or procedure, after the annual Deductible is satisfied. Services must be provided at a GHC Facility.

General anesthesia services and related facility charges in conjunction with any dental procedure performed in an ambulatory surgical center are covered subject to a \$150 facility Copayment after the annual Deductible is satisfied if such anesthesia services and related facility charges are Medically Necessary because the Enrollee:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
2. Has a Medical Condition that the Enrollee's physician determines would place the Enrollee at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Enrollee's physician.

Preauthorization by GHC is required for general anesthesia services and related facility charges.

For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

4. BLOOD AND BLOOD DERIVATIVES

Blood and blood derivatives, including, but not limited to, synthetic factors, plasma expanders, and their administration, are covered in full when Medically Necessary, after the annual Deductible is satisfied.

5. CHEMICAL DEPENDENCY TREATMENT

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

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

Chemical dependency treatment services are covered subject to the hospital inpatient or office visit Copayment, after the annual Deductible is satisfied and as set forth below at a GHC Facility or GHC-approved treatment program, subject to the \$14,500 benefit period Allowance. Any Cost Shares for chemical dependency services under the terms of the Agreement shall not be applied toward the benefit period Allowance.

1. Chemical Dependency Treatment Services. All alcoholism and/or drug abuse treatment services must be: (a) provided at a facility as described above; and (b) deemed Medically Necessary as defined above. Chemical dependency treatment may include the following services received on an inpatient or

outpatient basis: diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines.

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

2. Benefit Period. For the purposes of this section, "benefit period" shall mean a twenty-four (24) consecutive calendar month period during which the Enrollee is eligible to receive covered chemical dependency treatment services, as set forth in this section. The first benefit period shall begin on the first day the Enrollee receives covered chemical dependency services and shall continue for twenty-four (24) consecutive calendar months, provided that coverage under the Agreement remains in force. All subsequent benefit periods thereafter will begin on the first day Covered Services are received after the expiration of the previous twenty-four (24) month benefit period.

6. DIABETIC EDUCATION

Medically Necessary diabetic education is covered subject to a \$15 office visit Copayment for each visit, after the annual Deductible is satisfied. Services must be prescribed by a GHC Provider and approved by GHC.

7. DIAGNOSTIC X-RAY, NUCLEAR MEDICINE, ULTRASOUND AND LABORATORY SERVICES

Laboratory or diagnostic imaging, including, but not limited to, x-rays, ultrasound, mammography, nuclear medicine and allergy testing, provided by a GHC Provider are covered in full, after the annual Deductible is satisfied. Screening and diagnostic procedures during pregnancy, and related genetic counseling when Medically Necessary for prenatal diagnosis of congenital disorders, are included.

8. DIALYSIS - Outpatient

Outpatient professional and facility services necessary for dialysis when referred by a GHC Provider are covered in full subject to a \$15 Copayment for each dialysis treatment, after the annual Deductible is satisfied. Dialysis is covered while the Enrollee is temporarily absent from the Service Area. A temporary absence is an absence lasting less than twenty-one (21) days. Services must be preauthorized prior to departure from the Service Area.

9. DURABLE MEDICAL EQUIPMENT AND SUPPLIES (FOR HOME USE) AND PROSTHESES

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

The Agreement covers the rental or purchase of durable medical equipment and medical supplies (for home use) and prostheses at 80% of allowed charges, subject to preauthorization by the Enrollee's Personal Physician and if obtained through a GHC Provider. Not subject to the annual Deductible. Disposable supplies used for treatment of diabetes are covered under the "Prescription Drugs, Insulin, and Diabetic Supplies" benefit.

20% Coinsurance does not apply to the annual Out-of-Pocket Limit.

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

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

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

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

Covered services include:

1. the rental or purchase (at the option of GHC) of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees shall not exceed full purchase price);
2. diabetic equipment not covered in the pharmacy benefit;
3. casts, splints, crutches, trusses or braces;
4. oxygen and rental equipment for its administration;
5. ostomy supplies;
6. artificial limbs or eyes (including implant lenses prescribed by a GHC Provider and required as a result of cataract surgery or to replace a missing portion of the eye);
7. the initial external prosthesis and bra (limited to two (2) every six (6) months) necessitated by surgery of the breast, and replacement of these items when necessitated by normal wear, a change in Medical Condition, or when additional surgery is performed that warrants a new prosthesis and/or bra;
8. penile prosthesis when impotence is caused by a covered Medical Condition (not psychological), is a complication which is a direct result of a covered surgery, or is a result of an injury to the genitalia or spinal cord, and other accepted treatment has been unsuccessful;
9. a wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum payment of \$100 per person; and
10. breast pumps.

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

10. EMERGENCY/URGENT CARE

Emergency Care (See Terms Used in This Booklet for a definition of Emergency)

All services are covered subject to a \$75 Copayment. Not subject to the annual Deductible.

- A. At a GHC Facility. GHC will cover Emergency care for all Covered Services.
- B. At a Non-GHC Facility. Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:
 - 1. Payment of the Emergency care Copayment; and
 - 2. Notification of GHC by way of the GHC Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.
- C. Waiver of Emergency Care Cost Share.
 - 1. Waiver for Multiple Injury Accident. If two or more Enrollees in the same family require Emergency care as a result of the same accident, coverage for all Enrollees will be subject to only one (1) Emergency care Copayment.
 - 2. Emergencies Resulting in an Inpatient Admission. If the Enrollee is admitted to a GHC Facility directly from the emergency room, the Emergency care Copayment is waived. However, coverage will be subject to the inpatient services Copayment.
- D. Transfer and Follow-up Care. If an Enrollee is hospitalized in a non-GHC Facility, GHC reserves the right to require transfer of the Enrollee to a GHC Facility, upon consultation between a GHC Provider and the attending physician. If the Enrollee refuses to transfer to a GHC Facility, all further costs incurred during the hospitalization are the responsibility of the Enrollee.

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

Urgent Care (See Terms Used in This Booklet for a definition of Urgent Condition)

Inside the GHC Service Area, care for Urgent Conditions is covered only at GHC medical centers, GHC urgent care clinics or GHC Providers' offices, subject to

the applicable Copayment. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a GHC Provider.

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

11. HEARING EXAMINATIONS AND HEARING AIDS

Hearing examinations to determine hearing loss are covered, subject to a \$15 Copayment for each visit, after the annual Deductible is satisfied. Hearing aids and rental/repair, including fitting and follow-up care, are covered to a maximum plan payment of \$800 every 36 months, when authorized by a GHC Provider. Hearing aids are not subject to the annual Deductible.

12. HOME HEALTH

Home health care services, as set forth in this section, shall be covered in full (not subject to annual Deductible) when provided by and referred in advance by a GHC Provider for Enrollees who meet the following criteria:

- A. The Enrollee 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.
- B. The Enrollee requires intermittent skilled home health care services, as described below.
- C. A GHC Provider has determined that such services are Medically Necessary and are most appropriately rendered in the Enrollee's home.

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

Covered Services for home health care may include the following when rendered pursuant to an approved home health care plan of treatment: nursing care, physical therapy, occupational therapy, respiratory therapy, restorative speech therapy, durable medical equipment and medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Enrollee's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services. Not subject to the annual Deductible.

Excluded: custodial care and maintenance care, private duty or continuous nursing care in the Enrollee's home, housekeeping or meal services, care in any nursing home or convalescent facility, any care provided by or for a member of the patient's family and any other services rendered in the home which do not meet the definition

of skilled home health care above or are not specifically listed as covered under the Agreement.

13. HOSPICE CARE (INCLUDING RESPITE CARE)

Hospice care is covered in full in lieu of curative treatment for terminal illness for Enrollees who meet all of the following criteria, after the annual Deductible is satisfied:

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

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

- A. Covered Services. Care may include the following as prescribed by a GHC Provider and rendered pursuant to an approved hospice plan of treatment, after the annual Deductible is satisfied:
1. Home Services
 - a. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.
 - b. Continuous care services in the Enrollee's home when prescribed by a GHC Provider, as set forth in this paragraph. "Continuous care" means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Enrollee at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a GHC Provider determines that the Enrollee would otherwise require hospitalization in an acute care facility.
 2. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered in a facility designated by GHC's Hospice Program or GHC-

approved hospice program when authorized in advance by a GHC Provider and GHC's Hospice Program or GHC-approved hospice program.

Respite care is covered in full in the most appropriate setting for a maximum of five (5) days per occurrence in order to continue care for the Enrollee in the temporary absence of the Enrollee's primary care giver(s).

3. Other covered hospice services may include the following:
 - a. Drugs and biologicals that are used primarily for the relief of pain and symptom management.
 - b. Medical appliances and supplies primarily for the relief of pain and symptom management.
 - c. Durable medical equipment.
 - d. Counseling services for the Enrollee and his/her primary care-giver(s).
 - e. Bereavement counseling services for the family.

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

1. Financial or legal counseling services.
2. Meal services.
3. Custodial or maintenance care in the home or on an inpatient basis, except as provided above.
4. Services not specifically listed as covered by the Agreement.
5. Any services provided by members of the patient's family.

All other exclusions listed in Benefit Exclusions and Limitations apply.

14. HOSPITAL SERVICES

Hospital Inpatient Services:

This Agreement covers Medically Necessary hospital accommodation and inpatient services, supplies, equipment, and drugs prescribed by a GHC Provider for treatment of covered conditions (including, but not limited to, general nursing care, surgery, diagnostic tests and exams, radiation and x-ray therapy, blood and blood derivatives, bone and eye bank services, and take-home medications dispensed by the hospital at the time of discharge). Inpatient hospital services are subject to a \$200 Copayment per day to a maximum of \$600 per person per calendar year, after the annual Deductible is satisfied. Convalescent, custodial or domiciliary care is not covered.

Covered services under this benefit include those provided by the GHC Provider, specialist, surgeon, assistant surgeon (when deemed medically necessary) and anesthesiologist.

GHC must be notified of emergency admissions on the first working day following admission or as soon as medically reasonable.

GHC reserves the right to require the Enrollee's admission or transfer to a GHC Facility of its choice, upon consultation with the Enrollee's physician. If the Enrollee refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Enrollee's responsibility to pay.

Outpatient Hospital Services:

Services for outpatient surgery, day surgery, or short-stay obstetrical services (discharged within 24 hours of admission) are covered subject to a \$150 facility Copayment per surgery or procedure, after the annual Deductible is satisfied. Services must be provided at a GHC Facility.

Dental Anesthesia - Inpatient/Outpatient:

General anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital are covered, subject to the applicable inpatient/outpatient facility Copayment after the annual Deductible is satisfied, if such anesthesia services and related facility charges are Medically Necessary because the Enrollee:

1. Is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
2. Has a Medical Condition that the Enrollee's physician determines would place the Enrollee at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the Enrollee's physician.

Preauthorization by GHC is required for general anesthesia services and related facility charges in conjunction with any dental procedure. Dentist and oral surgeon fees are not covered.

For the purpose of this section, "general anesthesia services" means services to induce a state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command. Nitrous oxide analgesia is not reimbursable as general anesthesia.

15. MENTAL HEALTH CARE

Mental health services are covered only when: (1) determined by GHC to be Medically Necessary, (2) preauthorized by GHC, and (3) provided by a GHC psychiatrist (M.D.), GHC psychologist (Ph.D.), community mental health agency licensed by the Department of Health, state hospital, or other GHC Provider.

Inpatient: Professional and facility services for diagnosis and treatment of mental illness are covered at \$200 Copayment per day; maximum \$600 per person per calendar year, subject to GHC's preauthorization requirements and use of GHC Providers, after the annual Deductible is satisfied. This includes medically necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

Outpatient: Services for diagnosis and treatment of mental illness are covered at a \$15 Copayment per visit for up to 50 visits per calendar year, subject to the requirements to obtain prior authorization and to use GHC Providers, after the annual Deductible is satisfied. This includes Medically Necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa). Visits for the sole purpose of medication management do not apply to the 50-visit limit, and are instead covered as Medical Conditions.

Preauthorization is not required for emergency admissions, including involuntary commitment to a state hospital. This Agreement will cover court-ordered treatment only if determined by GHC to be Medically Necessary. All costs for mental health care in excess of the coverage provided under this Agreement, including the cost of any care for which the Enrollee failed to obtain prior authorization or any care obtained from other than a GHC Provider, will be the Enrollee's sole responsibility to pay.

16. NEURODEVELOPMENTAL THERAPY FOR CHILDREN AGE 6 AND YOUNGER

Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered, after the annual Deductible is satisfied. Coverage includes maintenance of a covered Enrollee in cases where significant deterioration in the Enrollee's condition would result without the services. Coverage for inpatient services is limited to 60 days per calendar year subject to \$200 Copayment per day; maximum of \$600 per person per calendar year, after the annual Deductible is satisfied and outpatient services is limited to 60 visits per calendar year subject to a \$15 Copayment per visit, after the annual Deductible is satisfied, as set forth in the Allowances Schedule.

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

17. NUTRITIONAL SERVICES

Phenylketonuria supplements are covered in full for treatment of this disorder after the annual Deductible is satisfied.

Outpatient total parenteral nutritional therapy, when Medically Necessary and in accordance with medical criteria as established by GHC, is covered in full after the annual Deductible is satisfied.

Outpatient elemental formulas for malabsorption, when Medically Necessary and in accordance with medical criteria as established by GHC, are covered at 80% after the annual Deductible is satisfied. Formulas for access problems are excluded.

Equipment and supplies for the administration of enteral and parenteral therapy is covered under Durable Medical Equipment and Supplies (for home use) and Prostheses.

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

18. OBSTETRIC AND NEWBORN CARE

Maternity care, including care for complications of pregnancy and prenatal and postpartum visits are covered subject to hospital inpatient and office visit Copayments after the annual Deductible is satisfied.

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

Hospitalization and delivery, including home births for low risk pregnancies. Planned home births must be authorized in advance by GHC.

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered, subject to the office visit or outpatient surgery Copayment after the annual Deductible is satisfied. Inpatient services related to voluntary and involuntary termination of pregnancy are covered, subject to the inpatient hospital Copayment after the annual Deductible is satisfied.

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

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

19. OFFICE AND CLINIC VISITS

Services provided by a GHC Provider, or a specialist when referred by the Enrollee's Personal Physician, are covered in full subject to a \$15 Copayment for each home, office or clinic visit after the annual Deductible is satisfied.

Family planning services are covered when provided by a GHC Provider or women's health care provider. Prescription contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps and long-acting progestational agents) determined most appropriate by a GHC Provider or women's

health care provider for use by the Enrollee are also covered. Elective sterilization is covered.

Self-Referrals to GHC acupuncturists and naturopaths for Covered Services as set forth in the Allowances Schedule after the annual Deductible is satisfied. Additional visits are covered when approved by GHC. Laboratory and radiology services are covered only when obtained through a GHC Facility.

Excluded: herbal supplements, preventive care visits to acupuncturists and naturopaths and any services not within the scope of their licensure.

20. ORGAN TRANSPLANTS

Transplant services including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy are covered subject to hospital inpatient or office visit Copayments when preauthorized by GHC and performed in a GHC Facility after the annual Deductible is satisfied.

Covered Services must be directly associated with, and occur at the time of, the transplant.

- Evaluation testing to determine recipient candidacy,
- Matching tests,
- Hospital charges,
- Procurement center fees,
- Professional fees,
- Travel costs for a surgical team,
- Excision fees,
- Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees,
- Follow-up services for specialty visits,
- Rehospitalization, and
- Maintenance medications.

Organ Transplant Recipient: All services and supplies related to the organ transplant for the Enrollee receiving the organ, including transportation to and from GHC Facilities (beyond that distance the Enrollee would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the Enrollee has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ Transplant Donor: The costs related to organ removal, as well as the cost of treating complications directly resulting from the surgery, are covered, provided the organ recipient is an Enrollee of a PEBB plan, and provided the donor is not eligible for coverage under any other health care plan or government-funded program.

Benefit Limitations: Transplants that are not preauthorized or are not performed in a GHC Facility are not covered. Benefits for costs relating to donor searches are provided only for allogeneic bone marrow transplants. Direct medical costs for up to 15 searches are covered. No other benefits are provided for services relating to locating a donor for organ transplants.

21. PHYSICAL, OCCUPATIONAL, SPEECH AND MASSAGE THERAPIES (Rehabilitation Services)

Treatment that is prescribed by the enrollee's PCP and is provided by a plan-designated provider and is approved by Group Health is covered for inpatient and outpatient physical, occupational, speech, and massage therapy services to restore or improve physical functioning due to a covered illness or injury. Inpatient rehabilitation therapy services are covered in full to a maximum of 60 days per calendar year, subject to the hospital inpatient copayment after the annual deductible is satisfied. Outpatient therapy services are covered in full to a maximum of 60 visits for all therapies combined per calendar year, subject to the office visit copayment after the annual deductible is satisfied.

The enrollee will not be eligible for both the "Neurodevelopmental Therapy" benefit and this benefit for the same services for the same condition.

22. PLASTIC AND RECONSTRUCTIVE SERVICES

Plastic and reconstructive services are covered as set forth below subject to the hospital inpatient and office visit Copayments after the annual Deductible is satisfied.

1. Correction of a congenital disease or congenital anomaly, as determined by a GHC Provider. A congenital anomaly will be considered to exist if the Enrollee's appearance resulting from such condition is not within the range of normal human variation.
2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHC which has produced a major effect on the Enrollee's appearance, when in the opinion of a GHC Provider, such services can reasonably be expected to correct the condition.
3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

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

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

Excluded: complications of noncovered surgical services.

23. PRESCRIPTION DRUGS, INSULIN AND DIABETIC SUPPLIES

This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Eligible Enrollees who are also eligible for Medicare Part D pharmacy benefits can remain covered under the Agreement and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date. An Enrollee who discontinues coverage under the Agreement must meet eligibility requirements in order to re-enroll.

The Agreement may include Medicare Part D pharmacy benefits as part of the GHC Medicare Advantage Plan required for Medicare eligible Enrollees who live in the GHC Medicare Advantage Service Area.

Retail

Up to a 30 day supply or refill of outpatient prescription drugs, insulin, and disposable diabetic supplies necessary for the treatment of diabetes, is covered subject to the Copayments explained below, or the actual cost of the prescription if less than the Copayment. The Enrollee may obtain up to a 90 day supply for an individual prescription at one filling, with the payment of three single-30 day Copayments. In order to receive a quantity sufficient for a 90 day supply, the prescription should specify that each fill is for 90 days or longer. Prescriptions written for a quantity sufficient for only a 30 day supply with the ability to refill for an additional 30 days or longer, may be limited to a 30 day supply per fill. Single-dose, long-acting drugs, and drugs packaged or dispensed in a single unit (such as inhalers) are subject to a single Copayment.

Generic drugs will be dispensed unless a suitable generic is not available. Generic drugs are defined as a drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are defined as a prescription drug that has been patented and is only available through one manufacturer. Approved drugs include federal legend drugs and insulin when prescribed by a GHC Provider. In the event the Enrollee elects to purchase brand name drugs instead of the generic equivalent (if available), or if the Enrollee elects to purchase a different brand name or generic drug than that prescribed by the Enrollee's Provider, and it is not determined to be Medically Necessary, the Enrollee will also be subject to payment of the additional amount above the applicable pharmacy Copayment. Any exclusion of drugs and medicines will also exclude their administration.

Formulary: A list of preferred pharmaceutical products that GHC, working with pharmacists and physicians, has developed to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. Contact GHC Customer Service to request a copy of the formulary.

Copayments:

\$10 Formulary generic drugs, all disposable diabetic supplies, and all insulin

\$30 Formulary brand-name drugs

Not subject to the annual Deductible.

Prescription drug Copayments do not apply to the annual Out-of-Pocket Limit.

GHC reserves the right to limit the quantity fill on an initial prescription to evaluate the therapeutic outcomes. GHC also reserves the right to limit the prescription quantity of any drug when a restricted dosage would constitute medically prudent and efficacious treatment.

Exception and Appeal Process: See Filing a Complaint or Appeal section on page 46.

Drugs must be prescribed by a GHC Provider and purchased at a GHC pharmacy. A limited supply of prescription drugs purchased from a non-GHC Facility or pharmacy is covered subject to the applicable pharmacy Copayment when dispensed or prescribed in connection with covered Emergency treatment.

Mail-Order Benefit

Covered medications are available through the mail order program subject to the Copayment set forth below when prescribed by a GHC Provider. The Enrollee must call the 24-hour Pharmacy Line at 1-800-245-7979 and leave a voicemail order. The Enrollees refill will be sent to them with no shipping charge. Allow 10 days for delivery. Covered prescription drugs include, but are not limited to medications used on a regularly scheduled basis for the treatment of chronic medical conditions such as hypertension, diabetes or asthma. Also covered through the mail order program are birth control pills; insulin; diabetic supplies including needles, syringes, lancets and test strips. Dosage and quantity limits will follow the formulary guidelines and/or standard medical practice. The quantity of new prescriptions may be limited to evaluate the therapeutic outcomes. GHC also reserves the right to limit the prescription quantity of any drug when a restricted dosage would constitute medically prudent and efficacious treatment.

Pharmacy Online

This service is available for refills only. Enrollees can order drugs, over-the-counter products, and special medical items on the GHC web site and have them delivered free of charge. To use this service, go to the MyGroupHealth home page at www.ghc.org. The Enrollee must register with MyGroupHealth and complete an ID verification process. Once the Enrollee has done that, they'll find a link to Pharmacy Online every time they log in to the MyGroupHealth home page.

The PEBB mail-order benefit level is:

- **Up to a 90-day supply**
- **\$20 Copayment for formulary generic drugs, all disposable diabetic supplies, and all insulin, and**
- **\$60 Copayment for formulary brand-name drugs**

Not subject to the annual Deductible.

Prescription drug Copayments do not apply to the annual Out-of-Pocket Limit.

Off-Label Drugs: FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

- a. "Off-label" means the prescribed use of a drug which is other than that stated in its FDA-approved labeling.
- b. "Standard Reference Compendia" means:
 - (1) The American Hospital Formulary Service-Drug Information;
 - (2) The American Medical Association Drug Evaluation;
 - (3) The United States Pharmacopoeia-Drug Information; or
 - (4) Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services.
- c. "Peer-reviewed Medical Literature" means scientific studies printed in 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.

The Enrollee's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Enrollees' right to know what drugs are covered under this Agreement and what coverage limitations are in this Agreement. Enrollees who would like more information about the drug coverage policies under this Agreement, or have a question or a concern about their pharmacy benefit, may contact GHC at (206) 901-4636 or 1-888-901-4636.

Enrollees 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 this Agreement, may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. Enrollees who have a concern about the pharmacists or pharmacies serving them, may call the Washington State Department of Health at 1-800-525-0127.

24. PREVENTIVE SERVICES

Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHC are covered in full. Not subject to the annual Deductible. Preventive care includes: routine mammography screening, physical examinations and routine laboratory tests for cancer screening including prostate screening in accordance with the well care schedule established by GHC, and immunizations and vaccinations listed as covered in the GHC drug formulary (approved drug list). A fee may be charged for health education programs. The well care schedule is available in GHC clinics, by accessing GHC's website at www.ghc.org, or upon request.

Covered Services provided during a preventive care visit, which are not in accordance with the GHC well care schedule, are subject to a \$15 Copayment.

25. RADIATION AND CHEMOTHERAPY SERVICES

Radiation and chemotherapy services are covered in full after the annual Deductible is satisfied when provided by a GHC Provider.

26. SKILLED NURSING FACILITY (SNF)

Skilled nursing care in a GHC-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending GHC Provider, is covered in full up to 150 days per calendar year, subject to a \$200 Copayment per day; maximum \$600 per person per calendar year after the annual Deductible is satisfied.

Additional coverage may be approved by GHC if the stay is in lieu of hospitalization.

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

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

27. SPINAL MANIPULATIONS

Self-Referrals for manipulative therapy of the spine and extremities are covered up to a maximum of ten (10) visits per Enrollee per calendar year subject to a \$15 Copayment per visit when provided by GHC Providers after the annual Deductible is satisfied.

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

28. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Medical services for the treatment of temporomandibular joint (TMJ) disorders are covered at 50% up to \$1,000 per calendar year after the annual Deductible is satisfied. Radiology services and TMJ specialist services are also covered. Such disorders may exhibit themselves in the form of pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food.

Excluded are the following: orthognathic (jaw) surgery including upper and lower jaw augmentation or reduction, except for congenital anomalies, treatment for

cosmetic purposes, dental services, including orthodontic therapy, TMJ appliances, TMJ splints, and any hospitalizations related to these exclusions.

29. TOBACCO CESSATION SERVICES

When provided through GHC, services related to tobacco cessation are covered in full, limited to:

1. Participation in one individual or group program per calendar year;
2. Educational materials; and
3. Approved pharmacy products, provided the Enrollee is actively participating in a GHC-designated tobacco cessation program.

Not subject to the annual Deductible.

30. VISION CARE (ROUTINE)

Routine eye examinations and refractions received at a GHC Facility once every twelve (12) consecutive months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered subject to a \$15 Copayment, after the annual Deductible is satisfied, as often as necessary upon recommendation of a GHC Provider.

Contact lenses for eye pathology, including contact lens exam and fitting, are covered subject to a \$15 Copayment after the annual Deductible is satisfied. When dispensed through GHC Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Enrollees following cataract surgery performed by a GHC Provider, provided the Enrollee has been continuously covered by GHC since such surgery.

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

Lenses and Frames

Not subject to the annual Deductible.

Benefits purchased at a Group Health-owned or contracted optical hardware provider may be used toward the following in any combination, over the benefit period, until the benefit maximum of \$150 once every 2 calendar years is exhausted:

- Eyeglass frames
- Eyeglass lenses (any type) including tinting and coating
- Corrective industrial (safety) lenses
- Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity

- Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations
- Replacement frames, for any reason, including loss or breakage
- Replacement contact lenses
- Replacement eyeglass lenses

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

31. WEIGHT CONTROL

Bariatric surgery and related hospitalizations are covered subject to the applicable Copayment, after the annual Deductible is satisfied when GHC criteria are met.

Excluded: pre and post surgical nutritional counseling and related weight loss programs, prescribing and monitoring of drugs, structured weight loss and/or exercise programs and specialized nutritional counseling.

Benefit Exclusions and Limitations

In addition to any exclusion listed in the previous pages, the plan does not cover the following:

1. Services not provided by a GHC Provider or obtained in accordance with GHC's standard Referral and authorization requirements, except for Emergency care or as covered under coordination of benefits provisions.
2. Non-participating providers are not covered inside or outside of the Service Area except for: emergencies; as specifically provided in the student eligibility section; or when otherwise specifically provided.
3. Experimental or investigational services, supplies and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the Enrollee had no health care coverage or for which the Enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a GHC Provider, except for Emergency treatment.
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including:
 - orthognathic surgery except for congenital anomalies;
 - myofascial pain dysfunction (MPD); and
 - dental implants.
11. Sexual reassignment surgery, services and supplies.

12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.
14. Services and supplies provided solely for the comfort of the Enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an Enrollee under this Agreement.
16. **Weight Control and Obesity Treatment.**

Non-surgical: Any weight loss or weight control programs, treatments, services, or supplies, even when prescribed by a physician, including, but not limited to, prescription and over-the-counter drugs, exercise programs (formal or informal), exercise equipment, or nutritional counseling (except as specified in the Diabetic Education benefit in this Certificate of Coverage). Travel expenses associated with non-surgical or surgical weight control or obesity services.

Surgical: Surgery for dietary or weight control, and any direct or non-direct complications arising from such non-covered surgeries, whether prescribed or recommended by a physician, including surgeries such as:

1. mini-gastric banding (gastric bypass using a Billroth II type of anastomosis)
2. distal gastric bypass (long limb gastric bypass)
3. bilopancreatic bypass and bilopancreatic with duodenal switch
4. jejunoileal bypass
5. gastric stapling or liposuction
6. removal of excess skin
7. bariatric surgery if you had bariatric surgery within the past 10 years.

The surgical exclusion for weight control and obesity treatment will not apply to preauthorized, Medically Necessary bariatric surgery of adult morbid obesity as specifically set forth in this Certificate of Coverage and the health plan's Bariatric Management criteria. More than one bariatric surgery for Enrollees will not be covered under the PEBB program.

17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes.
20. Routine foot care.
21. Services for which an Enrollee has a contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the Enrollee received double recovery for such services.
22. Any medical services or supplies not specifically listed as covered.
23. Direct complications arising from excluded services.
24. Pharmaceutical treatment of impotence or sexual dysfunction.
25. When Medicare coverage is primary, charges for services or supplies provided to Enrollees through a "Private Contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
26. Replacement of lost or stolen medications.

27. Recreation therapy.

How To Obtain Care Within the Service Area

Personal Physicians

Enrollees must select a GHC Personal Physician in their Service Area from the participating Provider Directory when enrolling under the Agreement. One Personal Physician may be selected for the entire family or a different Personal Physician may be selected for each family member. If the Personal Physician is not selected at the time of enrollment, GHC will assign a Personal Physician, and a letter of explanation and an ID card will be sent to the Enrollee.

The Enrollee may change from one Personal Physician to another by contacting one of GHC's Customer Service representatives, or accessing the GHC 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. GHC's 24 hour Consulting Nurse Service provides round-the-clock health care advice by phone. Many facilities also have urgent care hours in addition to regular hours.

Once the Enrollee changes Personal Physicians, any Referrals that were made by the Enrollee's previous Personal Physician will not be valid unless the Referral was preauthorized by GHC. The Enrollee must notify their new Personal Physician that they have been receiving services from a specialist, so the Enrollee's Personal Physician can make arrangements for them to continue to receive specialty care.

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

Specialty Care

Specialty care will be provided only when referred by the Enrollee's Personal Physician and authorized in advance and in writing by GHC except as noted under "Preauthorization and Referral Procedures." All care must be received from GHC Providers, except for Emergency care or care for dependent students outside the Service Area.

If the Enrollee needs specialized care, the Enrollee's Personal Physician will refer them to one of GHC's specialists. GHC specialists are unique because they work closely with the Enrollee's regular Personal Physician. They are part of the same team. The Enrollee's provider will know which specialist at GHC will have the expertise to match the Enrollee's particular situation. In some parts of the GHC Service Area, Enrollees are referred to carefully selected specialists in the community. If the Enrollee has a complex or serious medical or mental health condition, they may request a standing referral from their GHC Personal Physician for specialist services.

Preauthorization and Referral Procedures

Enrollees are required to use GHC Providers and GHC Facilities, except on prior written Referral by GHC, or for an Emergency or care for dependent students outside the Service Area. All inpatient services and use of ambulatory surgical centers in conjunction with any dental procedure require preauthorization by GHC.

Specialty care will be provided only when authorized in advance and in writing by the Enrollee's Personal Physician, with the exception of self-referred manipulative therapy, Women's Health Care specialists as noted below under "Self Referral for Women's Health Care," and visits with GHC-Designated Self-Referral Specialists.

GHC-Designated Self-Referral

Enrollees may make appointments directly with GHC-Designated Self-Referral Specialists at GHC-owned or -operated medical centers without a Referral from their Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine*, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose, and throat), physical therapy*, smoking cessation, speech/language and learning services*, and urology.

* Medicare patients need a Referral for these specialists.

Self-Referral For Women's Health Care

Female Enrollees may see the following GHC Providers of women's health care services without a Referral from their Personal Physician for Medically Necessary services:

- General and Family Practitioner,
- Physician's Assistant,
- Gynecologist,
- Certified Nurse Midwife,
- Doctor of Osteopathy,
- Obstetrician,
- Advanced Registered Nurse Practitioner
- Licensed Midwife
- Pediatrician

Women's health care services include:

- Medically Necessary maternity care,
- Covered reproductive health services,
- Preventive care and general examinations,
- Gynecological care, and
- Medically Necessary follow-up visits for the above services.

If the Enrollee's chosen provider diagnoses a condition that requires a Referral to other specialists or hospitalization, the Enrollee or his/her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHC requirements.

Women's health care services are covered as if the Enrollee's Personal Physician had been consulted, and are subject to all applicable Copayments, Coinsurances and Deductibles.

A listing of consulting referral specialists, women's health care providers, and GHC-Designated Self-Referral Specialists is available by contacting GHC Customer Service at (206) 901-4636 (or 1-888-901-4636), or by accessing GHC's website at www.ghc.org.

Second Opinions

Enrollees or the Enrollee's family may request a Referral from the Enrollee's Personal Physician, or may self-refer for visits with a GHC-Designated Self-Referral Specialist, for a second opinion. When second opinions are requested or indicated, they are provided by GHC Providers and are covered when **approved in advance**, or when obtained from a GHC-Designated Self-Referral Specialist. Coverage is determined by the Enrollee's medical coverage plan, therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered.

Referral for a second opinion does not imply that GHC will refer the Enrollee back to the physician providing the second opinion for the recommended treatment. Any diagnostic or therapeutic services must be initiated by the referring GHC Provider. Services, drugs, devices, etc., prescribed or recommended as a result of the Consultation are not covered unless included as covered under this Agreement.

Individual Case Management

When Medically Necessary and cost-effective, GHC may provide alternative benefits for Covered Services to an Enrollee on a case-by-case basis.

In order for GHC to provide alternative services, a written agreement that specifies services, supplies, benefits and limitations must be signed by the Enrollee, the Personal Physician and GHC. GHC reserves the right to terminate these extended benefits when the services are no longer Medically Necessary, cost-effective, feasible, or at any time by sending written notice to the Enrollee.

Home Health Care Alternative to Hospitalization

When provided at equal or lower cost, the benefits of this Agreement will be available for home health care instead of hospitalization or other institutional care when furnished by a GHC home health, hospice, or home care agency. Substitution of less expensive or less intensive services will be made only with the consent of the Enrollee, and when the Enrollee's physician or other GHC health care provider advises that the services will adequately meet the Enrollee's needs. GHC will base the decision to substitute less expensive or less intensive services on the Enrollee's individual medical needs. GHC may require a written treatment plan which is approved by the GHC Provider. Care will be covered on the same basis as for the

institutional care substituted. Benefits will be applied to the maximum plan benefit payable for hospital or other institutional expenses, and will be subject to any applicable Deductible, Copayment and Coinsurance amounts required under this Agreement.

Emergency Care

Emergency Services

In cases of accidental injury or medical Emergency, Emergency services are available at GHC Facilities. If, in the opinion of a prudent lay person, the nature of the Enrollee's condition is such that traveling to a GHC Facility would endanger the Enrollee's health, the Enrollee may obtain services from the most conveniently located licensed health care provider. The Enrollee must notify GHC within 24 hours of receiving services, or as soon as is medically reasonable, to ensure maximum coverage.

When the Enrollee is medically stabilized, GHC may require the Enrollee to be transferred to the care of a GHC Provider. If the Enrollee refuses to transfer to the specified facility, all costs incurred after the date the transfer could have occurred will be the Enrollee's responsibility to pay.

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

World-Wide Emergency Care - If the Enrollee is admitted to a non-GHC Facility outside the GHC Service Area due to an Emergency, the Enrollee or an Enrollee's family member must call the GHC Notification Line within 24 hours or as soon thereafter as is reasonably possible following the emergency.

OUTSIDE OF SERVICE AREA

Enrollees must permanently reside within the GHC Service Area in order to enroll under this Agreement.

Student Dependents

If one or more dependents live outside the area temporarily while attending an accredited secondary school, college, university, vocational school or school of nursing, they may receive benefits through any licensed physician. Claims for those providers will be paid as if the service had been received through GHC Providers. The dependents will be responsible for the same Copayments that apply to in-area Enrollees. For purposes of preauthorization, GHC will assume the role of the Personal Physician. GHC must authorize all services, including routine care, in advance, except when Emergency or urgent care is needed.

Reciprocity

PEBB Enrollees who are temporarily outside the GHC Service Area may have access to care with carriers that participate in reciprocity agreements with GHC. If the Enrollee plans to travel and wishes to obtain more information about the benefits available to them, they may call GHC's Customer Service Center at 1-888-901-4636.

How to Submit Claims

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

If an Enrollee receives a bill for Covered Services, the Enrollee must, within 60 days of the service date, or as soon thereafter as is reasonably possible, either a) contact GHC Customer Service to make a claim or b) pay the bill and submit a claim for reimbursement of Covered Services to GHC, P.O. Box 34585, Seattle, WA 98124-1585. In no event, except in the absence of legal capacity, shall a claim be accepted later than one (1) year from the service date.

GHC will generally process claims for benefits within the following timeframes after GHC 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 GHC for up to an additional fifteen (15) days. Enrollees will be notified in writing of such extension prior to the expiration of the initial timeframe.

Release of Information

Enrollees may be required to provide GHC or the HCA with information necessary to determine eligibility, administer benefits or process claims. This could include, but is not limited to, medical records. Benefits could be denied if Enrollees fail to provide such information when requested. Know that GHC does not disclose medical information related to the Enrollee's mental health, genetic testing results, and drug and alcohol abuse treatment records to third parties without the Enrollee's special consent/authorization or as required or permitted by law.

When the Enrollee has Other Medical Coverage

A. Coordination of Benefits

The coordination of benefits (COB) provision applies when an Enrollee has health care coverage under more than one plan. PEBB benefits will not be coordinated with any individual health care plan that covers the Enrollee. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

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

1. Definitions.

- a. **Plan.** A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Enrollees 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, blanket disability insurance contracts and group 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 Enrollee has health care coverage under more than one plan.

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

- d. **Allowable Expense.** Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Enrollee 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 an Enrollee 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 an Enrollee is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily

employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

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

2. Order of Benefit Determination Rules.

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

- a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- b. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

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

- c. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- d. Each plan determines its order of benefits using the first of the following rules that apply:
 - 1) Non-Dependent or Dependent. The plan that covers the Enrollee 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 Enrollee 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 Enrollee as a Dependent, and primary to the plan covering the Enrollee 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 Enrollee as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.
 - 2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

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

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

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

- 3) Active employee or retired or laid-off employee. The plan that covers an Enrollee as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Enrollee as a retired or laid off employee is the secondary plan. The same would hold true if an Enrollee is a Dependent of an active employee and that same Enrollee 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 an Enrollee 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 Enrollee as an employee, member, Subscriber or retiree or covering the Enrollee 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 Enrollee as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Enrollee the shorter period of time is the secondary plan.
- 6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

3. Effect on the Benefits of this Plan.

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expenses for that claim. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information.

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

5. Facility of Payment.

If payments that should have been made under this plan are made by another plan, GHC has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid

to the other plan are considered benefits paid under this plan. To the extent of such payments, GHC is fully discharged from liability under this plan.

6. Right of Recovery.

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

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

When the Enrollee has Medicare Coverage

Benefits are coordinated with Medicare coverage in the same way as they are coordinated with other coverages.

This PEBB plan is usually secondary to Medicare coverage. This PEBB plan will pay as primary for retirees enrolled in Medicare when the service or supply is covered by this PEBB plan but not by Medicare, such as for prescription drugs.

Medicare eligible PEBB Enrollees may still be required to pay Copayments in situations, such as when Medicare Deductibles have not been met, or when a service is not covered by Medicare.

When a Third Party Is Responsible for Injury or Illness (Subrogation)

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

"Injured Person" under this section means an Enrollee covered by this Agreement who sustains an injury, and any spouse, dependent, or other person or entity that may recover on behalf of such Enrollee (including the estate of the Enrollee and, if the Enrollee is a minor, the guardian or parent of the Enrollee). "GHC's Medical Expenses" means the expense incurred and the reasonable value of the services provided by GHC for the care or treatment of the injury sustained.

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

subrogated to and may enforce all rights of the Injured Person to the extent of GHC's Medical Expenses.

GHC's subrogation and reimbursement rights shall be limited to the excess of the amount required to fully compensate the Injured Person for the loss sustained, including general damages. However, in the case of Medicare Advantage Enrollees, GHC's right of subrogation shall be the full amount of GHC's Medical Expenses and is limited only as required by Medicare. Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, (including, but not limited to, any party's liability insurance or uninsured/underinsured motorist's funds), then GHC's Medical Expenses provided or to be provided to the Injured Person are secondary, not primary. As a condition of receiving benefits under this Agreement, the Injured Person agrees that acceptance of GHC services is constructive notice of this provision in its entirety and agrees to reimburse GHC for the benefits the Injured Person received as a result of the events causing the injury.

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

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

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

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

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

Uninsured or Underinsured Motorist Coverage

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

The Enrollee and his or her agents must cooperate fully with GHC in its efforts to enforce this provision. This cooperation shall include supplying GHC with information about any available insurance coverage. The Enrollee and his or her agents shall permit GHC, at GHC’s option, to associate with the Enrollee or to intervene in any action filed against any party related to the injury. The Enrollee and his or her agents shall do nothing to prejudice GHC’s right to enforce this provision. In the event the Enrollee fails to cooperate fully, the Enrollee shall be responsible for reimbursing GHC for such medical expenses.

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

GHC shall not pay any attorneys’ fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHC prior to any collection efforts. Under no circumstances will GHC pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHC.

Filing a Complaint or Appeal

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

The appeal process is available for an Enrollee to seek reconsideration of a denial of benefits.

Appeals for determination of ineligibility see Eligibility Section page 58.

Complaint Process:

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

Step 2: If the Enrollee is not satisfied or if he/she prefers not to talk with the person involved, the Enrollee 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 Enrollee's concerns. Most concerns can be resolved in this way.

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

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

Appeals Process:

Step 1: REGULAR APPEAL PROCESS

What the Enrollee must do: If the Enrollee wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. If the Enrollee is located west of the of the Cascade Mountains, appeals should be directed to GHC's Member Appeals Department, P.O. Box 34593, Seattle WA 98124-1593, (206) 901-7350, or toll free (866) 458-5479; or if the Enrollee is located east of the Cascade Mountains, to GHC's Member Appeals Department, P.O. Box 204, Spokane, WA 99210-0204, (509) 241-7622, or toll free (866) 458-5479.

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

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

Step 2:

What the Enrollee must do: If the Enrollee is not satisfied with the decision in Step 1 regarding a denial of benefits, or if GHC fails to grant or reject the Enrollee's request within the applicable required timeframe, he/she may request a second level review by

an external independent review organization as set forth under Independent Review Organization below. The Enrollee may also choose to pursue review by an appeals committee prior to requesting a review by an independent review organization as set forth below under Optional Hearing. This is not a required step in the appeals process.

INDEPENDENT REVIEW ORGANIZATION

What the Enrollee must do: Request a review by an independent review organization. An independent review organization is not legally affiliated or controlled by GHC. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through GHC.

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

REQUEST FOR AN OPTIONAL HEARING

Enrollees electing the appeals committee maintain their right to appeal further to an independent review organization as set forth above.

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

A request for a hearing by the appeals committee must be made within thirty (30) days after the date of the Step 1 decision notice.

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

EXPEDITED APPEAL PROCESS

There is an expedited appeals process in place for cases which meet criteria or where the Enrollee's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Enrollee's life, health or ability to regain maximum function or subject the Enrollee to severe pain that cannot be managed adequately without the requested care or treatment. The Enrollee can request an expedited appeal in writing to the above address, or by calling GHC's Member Appeals Department in western Washington at (206) 901-7350 or toll free 866-458-5479, or in eastern Washington at (509) 241-7622 or toll free 866-458-5479. The Enrollee's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

ELIGIBILITY

ELIGIBLE EMPLOYEES

Employees (referred to in this book as “employees,” “subscribers” or, in some cases, “enrollees”) of state government, higher education, participating K-12 school districts, educational service districts, and participating employer groups are eligible for enrollment in Public Employees Benefits Board (PEBB) medical plans as described in the PEBB eligibility rules in Washington Administrative Code (WAC), chapter 182-12 WAC. These rules are accessible through the PEBB Rules section on the PEBB web site at www.pebb.hca.wa.gov.

Eligibility for employees of participating “employer groups” must follow PEBB rules or provisions set in a collective bargaining agreement or terms of employment, if approved by the HCA in accordance with chapter 182-12-WAC.

ELIGIBLE DEPENDENTS

The following are eligible as dependents:

1. Lawful spouse
2. Domestic partner qualified by the PEBB declaration of domestic partnership that meets all of the following criteria;
 - Partners have a close personal relationship in lieu of a lawful marriage;
 - Partners are not married to anyone;
 - Partners are each other’s sole domestic partner and are responsible for each other’s common welfare;
 - Partners are not related by blood as close as would bar marriage; and
 - Partners are barred from lawful marriage in Washington State.
3. Domestic partner qualified by the certificate of state registered domestic partnership or registration card issued by the Washington Secretary of State for a same-sex partnership.
4. Children. Children are defined as the subscriber’s biological children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber’s qualified domestic partner, or children specified in a court order or divorce decree. In addition, children include extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber’s spouse, or the subscriber’s qualified domestic partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. “Children” does not include foster children for whom support payments are made to the subscriber through the state Department of Social and Health Services foster care program. Eligible children include:
 - a. Unmarried children through age nineteen.
 - b. Married children through age nineteen who qualify as dependents of the subscriber under the Internal Revenue Code.
 - c. Unmarried children age twenty through age twenty-three who are attending high school or are registered students at an accredited secondary school, college, university, vocational school, or school

of nursing (students). A married child is eligible as a student if the child is a dependent of the subscriber under the Internal Revenue Code. Students are certified annually and under certain circumstances may be eligible for year round enrollment (see WAC 182-12-260(4)).

- d. Unmarried children age twenty through age twenty-four (adult dependents). The subscriber must pay the adult dependent premium for adult dependents whom the subscriber has enrolled. Non-payment of premium will result in termination of coverage back to the end of the month the last full month premium was paid. Adult dependents must enroll in the same medical plan as the subscriber unless the dependent does not reside within the subscriber's medical plan service area or the subscriber has waived his or her medical plan in accordance with PEBB rule.
- e. Children of any age with disabilities, developmental disabilities, mental illness or mental retardation, who are incapable of self-support, provided such condition occurs before age twenty or during the time the dependent was eligible as a student. The subscriber must provide evidence that such disability occurred as stated below:
 - i. For a child enrolled in PEBB insurance coverage, the subscriber must provide evidence of the disability within sixty days of the child's attainment of age twenty.
 - ii. For a child enrolled in PEBB insurance coverage as a student, the subscriber must provide evidence of the disability within sixty days after the student is no longer eligible under PEBB rules.
 - iii. For a child, twenty or older, who is a new dependent or for a child, twenty or older, who is a dependent of a newly eligible subscriber, the child may be enrolled as a child with disabilities if the subscriber provides evidence that the condition occurred before the child reached age twenty or evidence that when the condition occurred the child would have satisfied PEBB eligibility for student coverage under PEBB rules had the subscriber been eligible for PEBB benefits at that time.
 - iv. The subscriber must notify the PEBB Program, in writing, no later than sixty days after the date the child age twenty or older no longer qualifies under PEBB rules.

Children age twenty and older who become capable of self-support do not regain eligibility as a child with disabilities under PEBB rules if they later become incapable of self-support. The PEBB Program will recertify children with disabilities periodically.

5. Parents.

- a. Parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as all of the following are met:
 - i. The parent maintains continuous enrollment in a PEBB medical plan;
 - ii. The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

- iii. The subscriber continues enrollment in PEBB insurance coverage;
and
- iv. The parent is not covered by any other group medical plan.
- b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not add additional dependents to their insurance coverage.

ENROLLMENT

PEBB enrollment rules are described in chapters 182-08 and 182-12 WAC. These rules are accessible through the PEBB Rules section of the PEBB web site at www.pebb.hca.wa.gov.

An employee or dependent is eligible to enroll in only one PEBB medical plan even if eligibility criteria are met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two or more parents employed by PEBB-participating employers may be enrolled as a dependent under one parent, but not more than one.

Employees may enroll in or waive enrollment in a medical plan for themselves or their dependents when they become eligible for PEBB benefits. If an employee waives medical coverage, medical coverage is automatically waived for all eligible dependents, with the exception of adult dependents who may enroll in a medical plan if the employee has waived medical plan enrollment. The employee must submit the appropriate enrollment form to their employing agency no later than 31 days after the date the employee becomes eligible for PEBB benefits. To enroll an adult dependent, the employee must submit the Adult Dependent Enrollment Form to the PEBB Program no later than 31 days after the date the employee becomes eligible for PEBB benefits.

Employees may enroll in or waive enrollment in a medical plan for themselves or their dependents during any annual open enrollment period. If the employee waives medical coverage, medical coverage is automatically waived for all eligible dependents, with the exception of adult dependents who may enroll in a medical plan if the employee has waived medical plan enrollment. The employee must submit the appropriate change form to their employing agency no later than the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year. To enroll an adult dependent, the employee must submit the Adult Dependent Enrollment Form to the PEBB Program no later than the end of the annual open enrollment.

Employees may enroll or waive enrollment for themselves or their dependents outside of the annual open enrollment under certain circumstances that create a special open enrollment event. However, the change in enrollment must correspond to the special open enrollment event. In addition, there are some circumstances when a dependent must be removed because the dependent no longer qualifies as an eligible dependent according to PEBB eligibility criteria. If the employee waives medical coverage, medical coverage is automatically waived for all eligible dependents, with the exception of adult dependents who may enroll in a medical plan if the employee has waived medical coverage. To enroll an adult dependent, the employee must submit the Adult Dependent Enrollment Form to the PEBB Program within the time limits described in PEBB rules.

Special open enrollment events are:

- Subscriber acquires an eligible dependent through marriage, domestic partnership, birth, adoption or placement for adoption, legal custody or legal guardianship;
- Subscriber loses an eligible dependent or a dependent no longer meets PEBB eligibility criteria;
- Subscriber has a change in marital status, including legal separation documented by a court order;
- Subscriber or a dependent loses comprehensive group health plan coverage;
- Subscriber or a dependent has a change in employment status that affects the employee's or the employee's dependent's eligibility, the level of benefits, or the cost of health plan coverage;
- Subscriber or a dependent has a change in place of residence that affects the employee's or the dependent's eligibility, the level of benefits, or cost of the health plan coverage;
- Subscriber receives a court order or medical support enforcement order requiring the employee, their spouse or qualified domestic partner to provide health plan coverage for an eligible dependent; or
- Subscriber receives a formal notice that the Department of Social and Health Services has determined it is more cost-effective to enroll an eligible dependent in a PEBB medical plan than a medical assistance program.

To make an enrollment change (enroll, waive or to remove a dependent who is no longer eligible) the employee must submit the appropriate form(s) to his or her employing agency. The employee must submit the form(s) no later than 60 days after the dependent no longer meets PEBB eligibility or no later than 60 days after the event, which created the special open enrollment, occurs. Employees should contact their payroll, personnel or insurance office to obtain the appropriate forms. In addition to the appropriate forms, the PEBB Program or employing agency may require the subscriber to provide evidence of eligibility or evidence of the event that created the special open enrollment.

Subscribers must remove dependents who no longer meet PEBB eligibility criteria as defined in WAC 182-12-260. Subscribers must report eligibility changes no later than 60 days after the event that creates a change in premium or loss of eligibility. The consequence for not reporting a change within 60 days after an event that creates a change in premium or loss of eligibility may include any one or all of the following:

- The dependent's loss of eligibility to continue health plan enrollment under one of the continuation options described in this certificate of coverage;
- The subscriber being billed for claims paid by the health plan for services after the dependent lost eligibility;
- The subscriber being billed for the difference in premium or not receiving a refund of premium which results from the change (see WAC 182-08-180); or
- The subscriber being responsible for premiums paid by the state for a dependent's health plan enrollment after the dependent lost eligibility.

WHEN MEDICAL COVERAGE BEGINS

For an employee and the employee's eligible dependent, enrolled when the employee is newly eligible, medical plan enrollment will begin when the employee's insurance coverage begins as defined in WAC 182-12-115. PEBB dependent eligibility is defined in WAC 182-12-260 and dependent enrollment requirements are described in WAC 182-12-262. These rules are accessible through the PEBB Rules section of the PEBB web site at www.pebb.hca.wa.gov.

For an employee or an employee's eligible dependent enrolled during the annual open enrollment, medical coverage will begin on January 1 of the upcoming year.

For an employee or an employee's eligible dependent enrolled in accordance with PEBB rules during a special open enrollment, medical coverage will begin the first of the month following the event that created the special open enrollment unless specifically described below:

- For an employee or the employee's spouse or newly eligible dependent child enrolled upon marriage. If the date of marriage is the first day of the month, medical coverage will begin on that date; otherwise it will begin the first of the following month.
- For an employee or the employee's qualified domestic partner or newly eligible dependent child enrolled upon declaration or registration of a domestic partnership (as defined in WAC 182-12-260). If the date of declaration or registration is the first day of the month, medical coverage will begin on that date; otherwise it will begin the first of the following month.
- For an employee's newborn child enrolled upon birth or a child enrolled by the employee in anticipation of the child being adopted. The child's medical coverage will begin on the date of birth or the date the employee assumes legal responsibility for the child in anticipation of adopting the child. For an employee or the employee's other eligible dependents enrolling due to the birth or adoption of a child, medical coverage will begin the first of the month in which the birth or adoption occurs.
- For a child with disabilities enrolled in accordance with PEBB rules, medical coverage begins on the first day of the month that eligibility is certified by the PEBB Program.
- For a student enrolled in accordance with PEBB rules, medical coverage begins on the first day of the month of the quarter or semester for which the child is certified as an eligible registered student (as defined in WAC 182-12-260). *Note:* A child may not be enrolled as a student outside of an open enrollment if he or she was eligible as a student, per WAC 182-12-260 in the previous quarter/semester.
- For an extended dependent acquired through legal custody or legal guardianship. If legal custody or legal guardianship begins on the first day of the month, medical coverage will begin on that date; otherwise it will begin the first of the following month.

MEDICARE ENTITLEMENT

If an enrollee becomes entitled to Medicare, they should contact the nearest Social Security Administration Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For employees and their spouses or qualified domestic partners age 65 and older, the PEBB medical plan will provide primary insurance coverage, and Medicare coverage will be secondary. However, employees age 65 and older may choose to reject his or her PEBB medical plan and choose Medicare as their primary insurer. If an employee does so, the employee will not be allowed to be enrolled in a PEBB medical plan. However, the employee will remain enrolled in PEBB dental, life and long-term disability insurance coverage.

In most situations, employees and their spouses/qualified domestic partners can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates or retires. If your entitlement is due to disability, contact Medicare regarding deferral. Upon retirement, Medicare will become the primary insurer, and the PEBB medical plan becomes secondary.

Please contact the PEBB Program for information about retiree eligibility and benefit information.

CHANGING MEDICAL PLANS

Subscribers may change medical plans during the annual open enrollment. The subscriber must submit the appropriate form(s) or make the change online no later than the end of the annual open enrollment.

In some situations, an employee may change medical plans outside of the annual open enrollment if a special open enrollment event occurs. The change in medical plan will begin the first of the month following the event, unless the special open enrollment is due to the birth or adoption of a child. If the special open enrollment event is the birth or adoption of a child, the change in medical plan will begin the first of the month in which the event occurred. The employee must submit the appropriate form(s) to his or her employing agency no later than 60 days after a special open enrollment event occurs and the change must correspond to one of the following events:

- Change in the enrollment status of the employee or the employee's dependent due to a special open enrollment event as described in the Enrollment section of this booklet.
- If an employee retires for any reason, the employee may change medical plans at the time of application for retiree insurance coverage. The change will become effective on the first day of the month following the retirement date.
- Subscribers may change medical plans when they or an eligible dependent becomes entitled to Medicare or enrolls in a Medicare Part D plan.
- Seasonal employees whose off-season occurs during annual open enrollment may change medical plans within 60 days of returning to work.
- If an employee's medical plan becomes unavailable, the employee may choose another medical plan within 60 days after notification by the PEBB Program. Anyone that does not choose another medical plan within this time period will be

enrolled in the contracted vendor's successor medical plan if one is available or will be enrolled in the Uniform Medical Plan by default. Anyone defaulted to the Uniform Medical Plan may not change medical plans until the next open enrollment.

- If the enrollee's physician stops participation with the enrollee's medical plan and the PEBB Appeals Manager determines that a continuity of care issue exists. Refer to WAC 182-08-198 for specific details.

If the employee is having premiums taken from payroll on a pre-tax basis, a medical plan change will not be approved if it would conflict with provisions of the state's salary reduction plan.

Employees should contact their payroll, personnel or insurance office for forms and information on how to update their records.

NOTE: If an enrollee's provider or health care facility discontinues participation with Group Health, the enrollee may not change medical plans until the next open enrollment period, unless the PEBB Appeals Manager determines that a continuity of care issue exists (for additional detail see WAC 182-08-198). Group Health cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us. Also, if an employee transfers from one employing agency to another during the year, the enrollee is not permitted to change medical plans, except as outlined above or in WAC 182-08-197.

WHEN MEDICAL ENROLLMENT ENDS

Medical plan enrollment ends on the earliest of the following dates:

1. For any individual who ceases to be eligible for PEBB insurance, coverage ends on the last day of the month in which eligibility ends.
2. For any person enrolled in the plan, coverage ends on the date the plan terminates, if that should occur. Persons losing coverage will be given the opportunity to enroll in another PEBB medical plan.
3. For an enrollee who declines the opportunity or is ineligible to continue enrollment in a PEBB medical plan under one of the options for continuing PEBB benefits described in this certificate of coverage, medical coverage ends for the employee and dependents at 12 o'clock midnight on the last day of the month in which the employee or dependent is eligible.
4. Premium payments are not prorated if an enrollee dies or cancels his or her medical plan prior to the end of the month.

If an enrollee, or newborn eligible for benefits under "Obstetric and Newborn Care," is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- the enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- the enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the skilled nursing facility confinement is in lieu of hospitalization;
- the enrollee is discharged from the skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- the enrollee is covered by another health plan which will provide benefits for the services; or
- benefits are exhausted.

When medical plan enrollment ends, the enrollee may be eligible for continuation of coverage or conversion to other health plan coverage if application is made within the timelines explained in the following sections.

As a PEBB enrollee it is the enrollee's responsibility to pay premiums when due. If the enrollee's account is delinquent, the enrollee's insurance coverage will be canceled at the end of the month in which the last full premium was received. **If the enrollee's insurance coverage is canceled due to delinquency, the enrollee's eligibility to participate in the PEBB benefits will end.**

The enrollee and their covered dependent(s) or beneficiary is responsible for reporting changes within 60 days after an event, such as divorce, termination of a qualified domestic partnership, death or when no longer a dependent as defined in WAC 182-12-260.

Failure to report changes can result in loss of premiums and loss of your or your dependent's right to continue coverage under the federal COBRA law or PEBB rules. If you need assistance in obtaining the proper form for communicating changes to the PEBB Program, please call PEBB Customer Service staff at 1-800-200-1004.

OPTIONS FOR CONTINUING PEBB BENEFITS

Employees and their dependents covered by this health plan have options for continuing insurance coverage during temporary or permanent loss of eligibility. There are four continuation coverage options you may be eligible for as a PEBB enrollee:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) Coverage
- PEBB retiree insurance coverage

The first three options temporarily extend group insurance coverage if certain circumstances occur that would otherwise end your or your dependent's PEBB medical plan and dental plan coverage. COBRA continuation coverage is governed by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility and procedural requirements defined in Washington Administrative Code (WAC) 182-12-171 or surviving dependents who meet eligibility requirements defined in WAC 182-12-250 or 182-12-265. These rules are accessible through the PEBB Rules section of the PEBB web site at www.pebb.hca.wa.gov.

All four options are administered by the PEBB Program. Refer to your PEBB Initial Notice of COBRA and Continuation Coverage Rights for specific details or call the PEBB Program Customer Service at 1-800-200-1004.

Employees also have the right of conversion to individual medical insurance coverage when continuation of group medical insurance coverage is no longer possible. The dependents of employees also have options for continuing insurance coverage for themselves following loss of eligibility.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Employees on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive up to 26 weeks of employer-paid medical, dental, basic life, and basic long-term disability insurance. These employees may also continue current optional and long-term disability insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay the employee premium contribution during this period to maintain eligibility. After that, insurance coverage may be continued as explained in the section titled "Options for Continuing PEBB Benefits."

PAYMENT OF PREMIUM DURING A LABOR DISPUTE

Any employee or dependent, whose monthly premiums are paid in full or in part by the employer, may pay premiums directly to Group Health or the HCA if the employee's compensation is suspended or canceled directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six (6) months.

During the period the employee's compensation is suspended or canceled, the employee shall be notified immediately by the HCA, in writing, by mail addressed to the last address of record with the HCA, that the employee may pay premiums as they become due as provided in this Section.

CONVERSION OF COVERAGE

Enrollees have the right to switch from PEBB group medical coverage to an individual conversion plan offered by Group Health when they are no longer able to continue the PEBB group medical plan, or are not eligible for Medicare or another group insurance coverage that provides benefits for hospital or medical care. Enrollees must apply for conversion coverage within 31 days after their group medical plan ends.

Evidence of insurability is not required to obtain the conversion coverage. The rates, coverage and eligibility requirements of our conversion program differ from those of the enrollee's current group medical plan. Enrollment in a conversion program may limit the enrollee's ability to later purchase an individual medical plan without health screening or

a preexisting condition waiting period. To obtain detailed information on conversion options under this medical plan, call Group Health.

APPEALS OF DETERMINATIONS OF INELIGIBILITY FOR BENEFITS

Any employee or employee's dependent aggrieved by a decision with regard to PEBB benefits may appeal that decision. Guidance on filing an appeal can be obtained in chapter 182-16 WAC (which governs PEBB appeals), the HCA web site's "Contact Us" page (www.pebb.hca.wa.gov) or by contacting the PEBB Appeals Manager through the PEBB Program Customer Service phone line at 1-800-200-1004.

RELATIONSHIP TO LAW AND REGULATIONS

The language of this Certificate of Coverage (COC) is based on the rules that administer the Health Care Authority's PEBB Program in chapters 182-08, 182-12, 182-16 WAC. In the case of a conflict between the rules and the language describing eligibility and enrollment in this COC, the rules shall govern. This agreement between the HCA and the contracted vendor for benefits shall be interpreted, administered, and enforced according to the laws and regulations of the state of Washington, except as preempted by federal law.

ENROLLEES' RIGHTS AND RESPONSIBILITIES

As a GHC Enrollee, you are entitled to certain rights such as dignity, privacy and informed participation in your treatment. With those rights come certain responsibilities.

As an Enrollee, you have the right:

- To be treated with respect and dignity by all Group Health staff.
- To privacy and confidentiality regarding your health and your care.
- To information about your rights and responsibilities as a patient and consumer.
- To information about Group Health, our practitioners and providers, and how to use our services.
- To receive timely access to quality care and services.
- To information about the qualifications of the professionals caring for you.
- To participate in decisions regarding your health care.
- To give consent to, or refuse care, and be told the consequences of consent or refusal.
- To an honest discussion with your practitioner about all your treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your medical condition and ability to understand.
- To join in decisions to receive, or not receive, life-sustaining treatment including care at the end of life.
- To create and update advance directives and have your wishes honored.
- To choose a personal primary care physician affiliated with Group Health.
- To expect your personal physician to provide, arrange, and/or coordinate your care.
- To change your personal physician for any reason.
- To be educated about your role in reducing medical errors and the safe delivery of care.
- To voice opinions, concerns, positive comments, or complaints.
- To appeal a decision and receive a response within a reasonable amount of time.
- To suggest changes to consumer rights and responsibilities and related policies.
- To receive written information in prevalent non-English language (as defined by the State).
- To receive oral interpretation services free of charge for all non-English languages.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To be free from all forms of abuse or harassment.
- To request and receive a copy of your medical records, and request amendment or correction to such documents, in accordance with applicable state and federal laws.

Your responsibilities as a Group Health Enrollee:

- To provide accurate information, to the extent possible, that Group Health requires to care for you. This includes your health history and your current condition. Group Health also needs your permission to obtain needed medical and personal information. This includes your name, address, phone number, marital status, dependents' status, and name of other insurance companies.

- To use practitioners and providers affiliated with Group Health for covered health care benefits and services. Emergencies or other situations authorized by Group Health are the exception.
- To know and understand your coverage, to follow plan procedures, and to pay for the cost of care not covered in your contract.
- To understand your health needs and to develop with your personal physician mutually agreed upon goals about ways to stay healthy or to get well when you are sick.
- To understand and follow instructions for treatment, and to understand the consequences of following or not following instructions.
- To be active, informed and involved in your care, and to ask questions when you do not understand your care or what you are expected to do.
- To be considerate of other members, your health care team, and Group Health. This includes arriving on time for appointments, and notifying staff if you cannot make it on time or if you need to reschedule.

Important Disclosure Information

We appreciate the trust you have placed in us in selecting a health plan offered through Group Health Cooperative. Various state and federal agencies regulate health plan carriers. Many regulations relate to information that you should have as an enrollee of a health plan. This document contains or references other sources of information that we are required to provide to you upon your enrollment into a health plan. If you have any questions about this information, please call Customer Service at 1-888-901-4636.

- **Health Plan Benefit Information** WAC 284-43-820 (1a)

Upon request, we will provide you with a listing of covered benefits and how enrollees may be involved in decisions about benefits. This information is summarized in your plan's summary of benefits document (available from your health plan carrier or your employer). This information is also detailed in this certificate of coverage.

- **Consumer involvement in benefit decisions** WAC 284-43-820 (1a)

Group coverage—Group enrollees can also participate as voting members of the Cooperative. Voting membership gives you the ability to influence the policies that govern the Cooperative. The purchaser of the group plan makes decisions about specific benefits that apply to your group medical coverage plan. Comments regarding benefit levels purchased by a group should be given to the group purchaser. Contact Customer Service for more information about becoming a voting member of Group Health Cooperative.

- **Documents referenced in medical coverage contracts or benefit booklets**

You can request to review documents referenced in this certificate of coverage, including your health plan's formularies on prescription drugs, durable medical equipment, and prosthetic appliances; documents detailing patient rights and responsibilities; and documents describing grievance procedures. WAC 284-43-820 (2a)

Annual accounting of payments made under a coverage plan: Your health plan carrier can provide you an annual accounting of all payments made by the health plan which counted towards any payment limitations, visit limitations, or other overall limitations on your coverage plan. WAC 284-43-820 (2f)

- **Accreditation status**

Accreditation status and health care effectiveness performance using the Health Employer Data Information Set (HEDIS®) is publicly reported by your health plan and is available to any interested person by calling Customer Service. WAC 284-43-820 (2h)

- **Quality Program**

A description of Group Health Cooperative's quality program and a report on our progress in meeting our goals is available upon request.

- **Grievance procedures**

Copies of grievance procedures for claim or service denial and for dissatisfaction with care are contained in your Certificate of Coverage and are also available by calling Customer Service. WAC 284-43-820 (1e, 2g)

Provider Information

- **A listing of participating primary care and specialty care providers**

Information about primary care providers is listed in your health plan's provider directory for your employer plan that is provided at open enrollment or is mailed to you. You can check the Group Health Web site at www.ghc.org for online provider selection information. Specific information about the specialists used in your health plan and which specialists are used by your primary care provider or attending physician is available through Customer Service. WAC 284-43-820 (1g)

- **How to access specialty care**

Specific information for your coverage plan about how to access specialty care and the referral authorization process is available in your health plan's member guide that is mailed to you upon enrollment. This information is also included in the provider directory. You can access emergency care on your own. Notification to the health plan is required if you are admitted to a noncontracted facility due to an emergency. Generally, nonemergency care must be authorized in advance by a primary care doctor and your health plan, including follow-up care subsequent to emergency care. Some covered services are available without a referral from your provider; check your benefit booklet or call Customer Service for more information. Health care obtained without a referral is reviewed retrospectively to ensure that medically appropriate care and services were delivered. Case management services are provided by your health plan to Enrollees with complex medical needs. WAC 284-43-820 (2b, 2c)

- **Provider compensation**

Your health plan's goal is to fairly compensate medical care providers for care that meets high professional standards. Providers are strongly encouraged to discuss all care options with their patients. There are no incentives to withhold such information nor are there incentives to withhold medically necessary services. A variety of provider compensation methods are used by the health plan carriers who have contracts with or employ the providers who render medical services to patients. Some providers are paid a salary for their services, some are paid a capitation fee (an amount that is paid monthly to a provider to provide a certain set of services for Enrollees), some are paid from a fee schedule (a predetermined amount that the health plan will pay for certain services), and some providers are paid at a discounted amount from their billed charges. At times, additional payments (a bonus

or an incentive payment) may be paid to an individual provider or provider group based on achieving specific customer satisfaction scores on standardized surveys or other specified performance measures, such as Enrollee access. WAC 284-43-820 (2d, 2e)

Women's Health and Cancer Rights

If you are receiving benefits for a covered mastectomy and elect breast reconstruction in connection with the mastectomy, you 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; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Mental Health Coverage Information

There are established standards to assure the competence and professional conduct of mental health service providers, to guarantee your rights to informed consent to treatment, to assure the privacy of your medical information and to guarantee your right to know the covered services and coverage limitation of your plan. If you have questions or concerns about any aspect of your mental health benefits, please contact Customer Service at 1-888-901-4636.

Pharmacy Benefit Information WAC 284-43-820 1(b), WAC 284-43-815, WAC 284-43-820 1(b)

Definitions of pharmacy related terms:

Drug formulary: A drug formulary is a list of preferred pharmaceutical products that health plans, working with pharmacists and physicians, have developed to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality.

Brand-name drug: A prescription drug that has been patented and is only available through one manufacturer.

Generic drug: A drug that is the pharmaceutical equivalent to one or more brand-name drugs. Such generic drugs have been approved by the U.S. Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand-name drug.

Your right to safe and effective pharmacy services

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

received from your plan may not conform to the terms of your contract, you may contact the Washington State Office of the Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the Washington State Department of Health at 1-800-525-0127.

Additional information beyond your covered benefits

In addition to a detailed list of covered benefits, you can get information about prescription drug coverage that may be included in your plan. Your health plan has a specific list of drugs, called a formulary, for those plans that include prescription drug coverage in the plan benefits. There is also a process that allows your provider to prescribe a drug that is not on the formulary list, or is only covered for certain conditions. Your doctor can request that a drug be covered under the medical plan due to medical necessity for a patient's specific medical condition. WAC 284-43-820 (1g)

Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?

Your health plan carrier, working with pharmacists and care providers, has developed a drug formulary to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. A drug formulary is a list of preferred pharmaceutical products. Nonformulary drugs are not covered unless approved by your health plan as medically necessary. Generic drugs will be dispensed unless a suitable generic is not available. If you elect to purchase a brand-name drug instead of the generic equivalent (if available), or if you elect to purchase a different brand-name or generic drug than that prescribed by your provider, you will be responsible for payment of the additional cost above the generic drug charge in addition to your plan pharmacy cost share. Vitamins, including legend (prescription) vitamins, and medicines and injections for anticipated illness while traveling, are generally excluded from all plans. Exclusion of other categories of drugs will depend on your specific coverage plan. For example, drugs for treatment of sexual dysfunction are not covered unless your medical plan covers treatment of sexual dysfunction. Contact Customer Service to request a copy of the drug formulary for your specific plan.

When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

Changes to the plan's drug formulary are implemented on an ongoing basis, based on an established evaluation process. The evaluation process includes review of scientific studies. The scientific studies reviewed must have been published 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. Your care provider or pharmacist will notify you when you refill a prescription if the prescribed drug is no longer included in the plan's drug formulary. When a drug has been removed from the plan formulary, it will not be covered unless your plan, at its discretion, elects to cover the drug for a limited time.

What should I do if I want a change from limitations, exclusions, substitutions, or cost increases for drugs specified in this plan?

Benefit changes—Customization of your drug benefit occurs only through the contract process. Employer groups may choose to purchase higher or lower drug benefits each year when they renew their group contract. Any enrollee can participate in decisions about the kind of health care services offered through participation as voting members in the Group Health consumer governance process.

Formulary substitution—Although individuals are not allowed to customize any plan drug formularies, medical providers can prescribe nonformulary medications for patients through a pharmacy exception process. The plan medical provider, in coordination with the plan pharmacy, will determine the medical appropriateness of substitutions. If a medical exception (substitution) is not approved, the patient is responsible for the full charge for the drug.

How much do I have to pay to get a prescription filled?

The amount of your out-of-pocket expense (cost share) depends on the specific pharmacy coverage you or your employer has purchased and on the medication prescribed. In general, the prescription copay or coinsurance amount applies for up to a 30-day supply of each covered prescription. If the actual charge for the drug is less than your cost share, you will pay only the actual charge for the drug. If your provider prescribes a noncovered medication, you will pay the actual charge for the drug. You will pay a lower cost share for generic drugs, and higher cost share for brand-name drugs.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

Yes. Some medical centers in our networks have their own pharmacies located within the medical center itself and some retail pharmacies are also under contract to provide covered prescription drugs for Enrollees. When you use one of these pharmacies designated for your plan, covered drugs are subject to the plan cost share, usually a copay. The plan directory of providers lists all the in-network pharmacies in your area.

How many days supply of most medications can I get without paying another copay or other repeating charge?

Your plan contract allows up to a 30-day supply of prescription or refill per copay or cost share amount. If you get a three-month supply of a maintenance drug, you will be charged three pharmacy copays or cost share amounts.

What other pharmacy services does my health plan cover?

A mail-order prescription refill service is available. Contact Customer Service for your plan's specific mail-order pharmacy benefits.

At Group Health Cooperative, the Pharmacy Department is involved in the development of clinical roadmaps and clinical guidelines. The Pharmacy Department participates in, or plays a role in, medication use and disease management programs for smoking cessation and for such conditions as diabetes, HIV/AIDS, asthma, depression, migraine headache, GERD (Gastroesophageal Reflux Disease), and heart problems.

Health Information Practices

1. Your health plan protects the confidentiality of Enrollee' health care information. The Group Health Confidentiality and Security Council and the Privacy Office have responsibility for overseeing protection of patient information. The council approves policies and standards concerning the security of confidential patient data, controls access to patient information and systems, establishes mechanisms to oversee the application of policies, and develops confidentiality and security awareness training. By policy, staff are required to sign confidentiality and security agreements. Information systems have password protection and require user identification. Only staff with a legitimate business need for patient information are granted access to information systems at a level of detail to suit their job requirements, and they are authorized to access patient information only for legitimate business purposes. We perform audits on staff access to patient information and have defined consequences for failure to comply with our confidentiality and security policies and procedures. Our trusted business partners that need patient information to fulfill their tasks must justify the need for specific pieces of information, use it solely for the purpose contracted, guarantee the same levels of security and confidentiality that we provide, and sign contracts containing provisions that protect the confidentiality of patient information.
2. Your health plan recognizes the right of competent patients to decide for themselves whether to accept or reject proposed medical treatment and to decide among recognized treatments. Before exercising this right, patients are entitled to receive sufficient information to reach an informed decision. When a patient is not competent to exercise the right to give informed consent to treatment, this right goes to the person legally authorized to provide such consent on the patient's behalf. In an emergency, a health care provider is authorized to provide necessary medical treatment without prior informed consent of the patient.
3. Other health information practices are described in the following Notice of Privacy Practices.

Notice of Privacy Practices of Group Health Cooperative and related organizations

Uses and disclosures of your personal health information

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice covers the privacy practices of the following organizations:

- Group Health Cooperative
- Group Health Options, Inc.
- Group Health Permanente, P.C.

Group Health's responsibilities

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Group Health must take steps to protect the privacy of your "protected health information"

(PHI.) PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Under federal law, we are required to:

- Protect the privacy of your PHI. All of our employees and Group Health Permanente physicians are required to maintain the confidentiality of PHI and receive appropriate privacy training.
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI.
- Follow the practices and procedures set forth in the Notice.

Uses and disclosures of your protected health information by Group Health that do NOT require your authorization

Group Health uses and discloses PHI in a number of ways connected to your treatment, payment for your care, and our health care operations. Some examples of how we may use or disclose your PHI without your authorization are listed below.

We may use or disclose your protected health information without your authorization as follows:

In relation to your health care and treatment:

- To our physicians, nurses, and others involved in your health care or preventive health care.
- To our different departments to coordinate such activities as prescriptions, lab work, and X-rays.
- To other health care providers treating you who are not on our staff such as dentists, emergency room staff, and specialists. For example, if you are being treated for an injured knee we may share your PHI among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

We may use or disclose your protected health information without your authorization as follows

In relation to payment:

- To administer your health benefits policy or contract.
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

We may use or disclose your protected health information without your authorization as follows

In relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we

may use your PHI to review and improve the care you receive, to provide training, and to help decide what rates to charge.

- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. Note: If we share your PHI with other organizations for this purpose, they must agree to protect your privacy.)

We may use or disclose your protected health information without your authorization for legal and/or governmental purposes in the following circumstances:

Required by law—When we are required to do so by state and federal law, including workers' compensation laws.

Public health and safety—To an authorized public health authority or individual to:

- Protect public health and safety.
- Prevent or control disease, injury, or disability.
- Report vital statistics such as births or deaths.
- Investigate or track problems with prescription drugs and medical devices by the Food and Drug Administration.

Abuse or neglect—To government entities authorized to receive reports regarding abuse, neglect, or domestic violence.

Oversight agencies—To health oversight agencies for certain activities such as audits, examinations, investigations, inspections, and licensures.

Legal proceedings—In the course of any legal proceeding in response to an order of a court or administrative agency and, in certain cases, in response to a subpoena, discovery request, or other lawful process.

Law enforcement—To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.

Military activity and national security—To the military and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.

We may also use or disclose your protected health information without your authorization in the following miscellaneous circumstances:

Family and friends—To a member of your family, a relative, a close friend — or any other person you identify who is directly involved in your health care — when you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest. For example, we may disclose PHI to a friend who brings you into an emergency room.

Facility directory information—Unless you object upon admission, we may use and disclose your name, the location at which you are receiving care, your general condition, and your religious affiliation in our facility directory. All of this information except

religious affiliation will be disclosed to people who ask for you by name. Members of the clergy will be told your religious affiliation if they ask. This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.

Appointment reminders—To you, to remind you in writing or by phone/voicemail that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.

Treatment alternatives and plan description—To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you, or to describe our health plan and providers to you.

Employer group health plans—If you are enrolled in Group Health through your work and your employer has adopted certain privacy procedures, we may communicate with your employer for certain administrative activities. (Please ask your employer for more details.)

Fundraising—To contact you for Group Health or Group Health Community Foundation fundraising purposes. (We would only release information such as your name, address, phone number, and dates that you received treatment or service from us.) You will be given the opportunity to instruct us to not contact you for this purpose.

Research—For Group Health or another organization's research purposes provided that certain steps are taken to protect your privacy. Note: Generally in these cases a research review board will review the research project to ensure adequate privacy protections before Group Health uses or discloses your PHI.

De-identify information—To “de-identify” information by removing information from your PHI that could be used to identify you

Coroners, funeral directors, and organ donation—To coroners, funeral directors, and organ donation organizations as authorized by law.

Disaster relief—To an authorized public or private entity for disaster relief purposes. For example, we might disclose your PHI to help notify family members of your location or general condition.

Threat to health or safety—To avoid a serious threat to the health or safety of yourself and others.

Correctional facilities—If you are an inmate in a correctional facility we may disclose your PHI to the correctional facility for certain purposes, such as providing health care to you or protecting your health and safety or that of others.

Uses and disclosures of your protected health information by Group Health that require us to obtain your authorization

Except in the situations listed in the sections above, we will use and disclose your PHI only with your written authorization.

In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose that specially protected PHI. In these situations, we will contact you for the necessary authorization. If you have questions about these laws, please contact the Privacy Office at 206-448-2422.

If you sign an authorization you may revoke it at any time in writing, although this will not affect information that we disclosed before you revoked the authorization.

If you would like to ask us to disclose your PHI, please contact the Privacy Office at 206-448-2422 for an authorization form.

Your rights regarding your protected health information

Note: You may exercise any of the rights described below, or ask questions about these rights, by contacting the Privacy Office at 206-448-2422.

You have the right to:

- Request restrictions by asking that we limit the way we use or disclose your PHI for treatment, payment, or health care operations. You may also ask that we limit the information we give to someone who is involved in your care, such as a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation.
- Ask that we communicate with you by another means. For example, if you want us to communicate with you at a different address we can usually accommodate that request. We may ask that you make your request to us in writing. We will agree to reasonable requests.
- Request a copy of your PHI. We may ask you to make this request in writing and we may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- Ask us to amend PHI about you that we use to make decisions about you. Your request for an amendment must be in writing and provide the reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included with your PHI.
- Seek an accounting of certain disclosures by asking us for a list of the times we have disclosed your PHI. Your request must be in writing and give us the specific information we need in order to respond to your request. You may request disclosures made up to six years before your request. You may receive one list per calendar year at no charge. If you request another list during the same year, we may charge you a reasonable fee. These lists will not include disclosures to other organizations that might pay for your care provided by Group Health.
- Request a paper copy of this Notice.

Changes to privacy practices

Group Health may change the terms of this Notice at any time. The revised Notice would apply to all PHI that we maintain. If we change any of the practices described in this

Notice, we will post the revised Notice on enrollee-accessible web sites and at Group Health clinics.

Questions and complaints

If you have general questions about this Notice or would like an additional copy, please call Customer Service at 206-901-4636 or toll free at 888-901-4636.

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may file a written complaint with Betty Doyle, Privacy Officer, W2N, Group Health Cooperative, 320 Westlake Ave N Ste 100, Seattle, WA 98109-5233. For more information on how to file a written complaint, call the Privacy Office at 206-448-2422. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized if you file a complaint about our privacy practices with us or with Health and Human Services.

OTHER SERVICES

Non-PEBB benefits available to Plan Enrollees

The benefits on this page are not part of the PEBB contract or premium, and you cannot file a PEBB disputed claim about them. Fees you pay for these services do not count toward PEBB deductibles or catastrophic protection out-of-pocket maximum.

MyGroupHealth – Online health care services	
<p>MyGroupHealth is your one-stop location for online health information, tools, and services.</p> <p>All Enrollees can use MyGroupHealth to order prescription refills and have them delivered to home with no shipping charge. You can also access valuable health risk assessment tools, choose or change your doctor, get medical center locations and programs, browse more than 10,000 health care topics, and more.</p> <p>And when you get care at Group Health medical centers, you can send and receive secure e-mail to and from your health care team, request appointments, get test results, view your online medical record, check benefit information, and more.</p> <p style="text-align: center;">For more information, visit MyGroupHealth at www.ghc.org</p>	
Health Products	
<p style="text-align: center;">Take Care Stores</p> <p>Our GHC Take Care store sells self-care and wellness products for knee, back, & neck care, blood pressure monitors, allergy-control bedding, weight management, sports therapy & exercise, and much more. Visit our Take Care Store located at our Group Health–Capitol Hill Facility, or you can order directly online from the Take Care website</p> <p>www.take-care.com</p>	<p style="text-align: center;">Hear Centers</p> <p>Group Health's Hear Centers offer a full range of the latest hearing aid technology from the world's leading manufacturers. Plus, custom noise plugs, swim molds, assistive listening devices, accessories, and batteries.</p> <p>Locations: Everett, Redmond/Bellevue, Seattle/Central, Tacoma, and Olympia.</p> <p>www.thehearcenter.com</p>
Health Programs	
<p style="text-align: center;">Weight Management Program</p> <p>Group Health's Weight Management program offers a total lifestyle plan. It teaches positive behaviors that promote health, and helps improve overall well-being through weight management.</p> <p>206-527-6920 in Seattle or 1-888-874-7783</p> <p>www.ghc.org/products/weight_management</p>	<p style="text-align: center;">Smoking Cessation</p> <p>Group Health offers help with smoking cessation through the Free & Clear program. Any currently enrolled Group Health Enrollee may participate in Free & Clear.</p> <p>Call Free & Clear at 1-800-462-5327</p> <p>www.ghc.org/products/freeclr.jhtml</p>
<p>For more information about these and other benefits available to Group Health Enrollees, please call Group Health Customer Service toll free at 1-888-901-4636 or visit our web site at www.ghc.org.</p>	