

Dear Group Health Options Subscriber:

This booklet contains important information about your healthcare plan.

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

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

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

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

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

Very truly yours,

Scott Armstrong
President

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Section I. Introduction

Group Health Options, Inc. (also referred to as “GHO”) is a Health Care Service Contractor, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepayment basis.

Read This Benefit Booklet Carefully

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

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

A. Accessing Care

Members are entitled to Covered Services from:

- GHO’s Preferred Provider Network, referred to as “PPN,”
- Community Providers, *or*
- *Qualified worldwide providers (emergent/urgent care only).*

Members may choose either health care delivery option at any time during or for differing episodes of illness or injury, except during a scheduled inpatient admission.

Benefits paid under one option will not be duplicated under the other option. All benefits under the Agreement are limited to Covered Services that are Medically Necessary and in the case of out of network services, Usual, Customary and Reasonable.

Under the Agreement, the level of benefits available for services received at the PPN is generally greater than the level of benefits available for services received from Community Providers. In order for services to be covered at the higher benefit level, services must be obtained from PPN Providers at PPN Facilities, except as follows:

- Emergency care,
- Other services as specifically set forth in the Allowances Schedule and Section IV.

Primary Care. One Preferred Provider may be selected for an entire family, or a different Preferred Provider may be selected for each family member.

A listing of Preferred Providers is available by contacting GHO Customer Service at (206) 901-4636 or (888) 901-4636, or by accessing GHO’s website at www.ghc.org.

Second Opinions. The Member may access, upon request, a second opinion regarding a medical diagnosis or treatment plan from a PPN Provider. The Member may also access a second opinion from a Community Provider, subject to the Community Provider benefit level.

Emergent and Urgent Care. Emergent care is available at PPN Facilities. If Members cannot get to a PPN Facility, Members may obtain Emergency services from the nearest hospital. Members may refer to Section IV. for more information about coverage of Emergency services under the PPN and Community Provider options.

Under the PPN option, urgent care is covered at PPN medical centers, PPN urgent care clinics or PPN Provider's offices. Members may refer to Section IV. for more information about coverage of urgent care services.

Under the Community Provider option, urgent care is covered at any medical facility. Members may refer to Section IV. for more information about coverage of urgent care services.

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

Unusual Circumstances. Under the PPN option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as complete or partial destruction of PPN Facilities, military action, civil disorder, labor disputes or similar causes, GHO shall ensure that its PPN provide and arrange for services that are emergent or urgently needed. In regard to nonurgent and routine services, GHO shall make a good faith effort to make the then-existing PPN Facilities and personnel available. The PPN shall have the option to defer or reschedule services that are not urgent while its facilities and services are so affected. In no case shall GHO have any liability or obligation on account of delay or failure to provide or arrange such services.

Under the Community Provider option, if the provision of Covered Services is delayed or rendered impossible due to unusual circumstances such as military action, civil disorder, labor disputes, or similar causes, in no case shall GHO have any liability or obligation on account of delay.

B. Cost Shares

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

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

2. Annual Deductible.

a. PPN. Covered Services received from a PPN Provider are subject to the annual Deductible as set forth in the Allowances Schedule.

Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met. In order for charges to be applied to the annual Deductible, Covered Services must be obtained at PPN Facilities, unless the Member has received Emergency services according to the Schedule of Benefits, Section IV.L.

b. Community Provider. Covered Services received from a Community Provider are subject to the annual Deductible as set forth in the Allowances Schedule.

Charges subject to the annual Deductible shall be borne by the Subscriber during each calendar year until the annual Deductible is met.

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

3. **Individual Annual Deductible Carryover.** Under *this Agreement*, charges *from the last three (3) months of the prior year which were* applied toward the individual annual Deductible *will also apply to the current year individual* annual Deductible. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate Family Unit Deductible does not carry over into the next year.
4. **Coinsurance.** After the annual Deductible is satisfied, Members shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

A benefit-specific coinsurance may apply to some Covered Services, as set forth in the Allowances Schedule. Services that are subject to the benefit-specific coinsurance are not subject to the Plan Coinsurance *and do not apply to the Out-of-Pocket Limit*.

5. **Out-of-Pocket Limit.** Under the PPN option, total Out-of-Pocket Expenses incurred during the same calendar year shall not exceed the Out-of-Pocket Limit set forth in the Allowances Schedule. Out-of-Pocket Expenses which apply toward the Out-of-Pocket Limit are set forth in the Allowances Schedule.

C. Subscriber's Liability

The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Cost Share amounts for Covered Services provided to the Subscriber and his/her Dependents, as set forth in the Allowances Schedule; (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents, at the time of service and (4) payment for any services not considered Medically Necessary or that are in excess of Usual, Customary and Reasonable charges.

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

D. Claims

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

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

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

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

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

Section II. Allowances Schedule

PPN: Describes coverage when care is provided by a Preferred Provider. Benefits paid under the PPN option will not be duplicated under the Community Provider option.

Community Provider: Describes coverage when care is provided by a Community Provider. Coverage is limited to the Usual, Customary and Reasonable (UCR) charges, less any applicable Cost Share amounts as noted below. Benefits paid under the Community Provider option will not be duplicated under the PPN option.

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

“Welcome” Outpatient Services Waiver

Not applicable.

Annual Deductible

PPN: \$200 per Member or \$600 per Family Unit per calendar year.

Community Provider: \$400 per Member or \$1,200 per Family Unit per calendar year.

Plan Coinsurance

PPN: Plan Coinsurance share is 90%; Member coinsurance share is 10%, after the annual Deductible is satisfied.

Community Provider: Plan Coinsurance share is 70% of the Usual, Customary and Reasonable charges; Member coinsurance share is 30%, after the annual Deductible is satisfied.

Lifetime Maximum

No Lifetime Maximum *on covered Essential Health Benefits.*

Hospital Services

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

PPN: Covered at the applicable Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

- Covered outpatient hospital surgery (including ambulatory surgical centers)

PPN: Covered subject to the lesser of the PPN’s charge or a \$75 Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or a \$75 outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

Outpatient Services

- Covered outpatient medical and surgical services

PPN: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

- Allergy testing

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Oncology (radiation therapy, chemotherapy)

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

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

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less

PPN: Generic drugs listed in the GHO drug formulary (Tier 1) - Covered subject to the lesser of the PPN's charge or a \$10 Copayment.

Brand name drugs listed in the GHO drug formulary (Tier 2) - Covered subject to the lesser of the PPN's charge or a \$25 Copayment.

Non-formulary generic and brand name drugs (Tier 3) - Covered subject to the lesser of the PPN's charge or a \$50 Copayment.

Community Provider: Generic drugs listed in the GHO drug formulary (Tier 1) - Covered subject to the lesser of the allowed charge or a \$15 Copayment.

Brand name drugs listed in the GHO drug formulary (Tier 2) - Covered subject to the lesser of the allowed charge or a \$30 Copayment.

Non-formulary generic and brand name drugs (Tier 3) - Covered subject to the lesser of the allowed charge or a \$55 Copayment.

- Over-the-counter drugs and medicines

Not covered.

- Injectables

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

Community Provider: Injectables that can be self-administered are subject to the lesser of the allowed charge or the applicable prescription drug Cost Share (as set forth above). Other covered injectables are subject to the

lesser of the allowed charge or the applicable outpatient services Cost Share. Injectables necessary for travel are not covered.

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

Covered subject to the lesser of GHC's charge or two (2) times the applicable prescription drug Cost Share (as set forth above) for each ninety (90) day supply or less for mail order prescription drugs.

Out-of-Pocket Limit

PPN: Limited to an aggregate maximum of \$1,500 per Member or \$4,500 per family per calendar year. Except as otherwise noted in this Allowances Schedule, the total Out-of-Pocket Expenses for the following Covered Services are included in the Out-of-Pocket Limit:

- Plan Coinsurance
- Emergency care at a PPN Facility
- Ambulance services

Community Provider: No limit.

Acupuncture

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance up to a maximum of twelve (12) visits per Member per calendar year, after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance up to a maximum of twelve (12) visits per Member per calendar year, after the annual Deductible is satisfied.

Ambulance Services

- Emergency ground/air transport

PPN: Covered at the applicable Plan Coinsurance for transport to a PPN Facility after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance for transport to a non-PPN Facility after the annual Deductible is satisfied.

- Non-emergent ground/air interfacility transfer

PPN: Covered at the applicable Plan Coinsurance for PPN-initiated transfers after the annual Deductible is satisfied, except hospital-to-hospital ground transfers are covered in full.

Community Provider: Covered at the Plan Coinsurance for transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment when prescribed by the attending physician, after the annual Deductible is satisfied.

Chemical Dependency

- Inpatient services (including Residential Treatment services)

PPN: Covered subject to the lesser of the PPN's charge or the applicable inpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable inpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Outpatient services

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

Acute detoxification covered as any other medical service.

Dental Services (including accidental injury to natural teeth)

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

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

Devices, Equipment and Supplies (for home use)

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

PPN: Covered in full.

Community Provider: Covered in full after the annual Deductible is satisfied.

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

Diabetic Supplies

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

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

Diagnostic Laboratory and Radiology Services

PPN: Covered at the applicable Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

Emergency Services

PPN: Covered subject to the lesser of the PPN's charge or a \$100 Copayment per Member per Emergency visit at a PPN Facility and at the applicable Plan Coinsurance after the annual Deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Community Provider: Covered subject to a \$100 Copayment or total charge of services, whichever is less, at a non-PPN Facility and at the applicable PPN Plan Coinsurance after the PPN annual Deductible is satisfied. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Copayment is waived if the Member is admitted as an inpatient to a non-PPN hospital directly from the emergency department.

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Hearing aids, including hearing aid examinations

PPN: Not covered.

Community Provider: Not covered.

Home Health Services

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered in full up to 130 visits per Member per calendar year.

Community Provider: Covered at the Plan Coinsurance up to 130 visits per Member per calendar year, after the annual Deductible is satisfied.

Hospice Services

PPN and Community Provider benefit limits are combined and cannot be duplicated.

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

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence.

Infertility Services (including sterility)

PPN: Not covered.

Community Provider: Not covered.

Manipulative Therapy

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Cost Share for manipulative therapy of the spine and extremities in accordance with GHO clinical criteria up to a maximum of twenty-four (24) visits per Member per calendar year.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Cost Share for manipulative therapy of the spine or extremities up to a maximum of twenty-four (24) visits per Member per calendar year.

Massage Therapy Services

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance for up to twelve (12) visits per calendar year after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance for up to twelve (12) visits per calendar year after the annual Deductible is satisfied.

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

PPN: Covered subject to the lesser of the PPN's charge or the applicable inpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable inpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Prenatal and postpartum care

PPN: Routine care covered at the applicable Plan Coinsurance after the annual Deductible is satisfied. Non-routine care covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Routine care covered at the applicable Plan Coinsurance after the annual Deductible is satisfied. Non-routine care covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Pregnancy termination

PPN: Covered subject to the lesser of the PPN's charge or the applicable Copayment and Plan Coinsurance for involuntary/voluntary termination of pregnancy after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable Copayment and at the Plan Coinsurance for involuntary/voluntary termination of pregnancy after the annual Deductible is satisfied.

Mental Health Services

- Inpatient services

PPN: Covered subject to the lesser of the PPN's charge or the applicable inpatient services Copayment and Plan Coinsurance at a GHO-approved mental health care facility after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable inpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Outpatient services

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

Naturopathy

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance up to a maximum of twelve (12) visits per Member per calendar year, after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance up to a maximum of twelve (12) visits per Member per calendar year, after the annual Deductible is satisfied.

Nutritional Services

- Phenylketonuria (PKU) supplements

PPN: Covered in full.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

- Enteral therapy (formula)

PPN: Covered at 80% for elemental formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies. Coinsurance does not apply to the Out-of-Pocket Limit.

Community Provider: Covered at the Plan Coinsurance for elemental formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

- Parenteral therapy (total parenteral nutrition)

PPN: Covered at the applicable Plan Coinsurance for parenteral formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Community Provider: Covered at the Plan Coinsurance for parenteral formulas after the annual Deductible is satisfied. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.

Obesity Related Services

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

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

On the Job Injuries or Illnesses

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

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

Optical Services

- Routine eye examinations

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance as often as Medically Necessary, after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance once every twelve (12) months, after the annual Deductible is satisfied.

- Lenses, including contact lenses, and frames

Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting - Covered up to \$200 per twelve (12) month period per Member. The benefit period begins on the date services are first obtained and continues for twelve (12) months. Lenses and frames are not subject to the annual Deductible or Plan Coinsurance.

- Contact lenses for eye pathology, including following cataract surgery

PPN: Covered in full.

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied.

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

Covered subject to the lesser of the PPN's charge or two (2) times the applicable prescription drug Cost Share (as set forth above) for each ninety (90) day supply or less for mail order prescription drugs.

Organ Transplants

PPN: Covered subject to the lesser of the PPN's charge or the applicable Cost Share.

Community Provider: Not covered.

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

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

PPN: Covered subject to the lesser of the PPN's charge or the applicable Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Cosmetic surgery, including complications resulting from cosmetic surgery

PPN: Not covered.

Community Provider: Not covered.

Podiatric Services

- Medically Necessary foot care

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

- Foot care (routine)

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

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

Pre-Existing Condition

Covered with no wait.

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

PPN: Covered *in full* when in accordance with the well care schedule established by *GHO and the Patient Protection and Affordable Care Act of 2010*. Not subject to the annual Deductible *or any applicable Plan Coinsurance*. Health education programs are covered at 50% to a maximum of \$250 per Member per calendar year. Eye refractions are not included under preventive care. Physicals for travel, employment, insurance or license are not covered.

Services provided during a preventive care visit which are not in accordance with the well care schedule *may be* subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Cost Share when in accordance with the well care schedule established by GHO. Not subject to the annual Deductible or any applicable Plan Coinsurance. Routine mammography services are covered at the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance after the annual Deductible is satisfied.

Rehabilitation Services

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

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable inpatient services Copayment and Plan Coinsurance for up to sixty (60) days per calendar year after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable inpatient services Copayment and at the Plan Coinsurance for up to sixty (60) days per calendar year after the annual Deductible is satisfied.

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

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable outpatient services Copayment and Plan Coinsurance for up to sixty (60) visits per calendar year after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance for up to sixty (60) visits per calendar year after the annual Deductible is satisfied.

Sexual Dysfunction Services

PPN: Not covered.

Community Provider: Not covered.

Skilled Nursing Facility (SNF)

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered at the applicable Plan Coinsurance for up to sixty (60) days per Member per calendar year after the annual Deductible is satisfied.

Community Provider: Covered at the Plan Coinsurance for up to sixty (60) days per Member per calendar year after the annual Deductible is satisfied.

Sterilization (vasectomy, tubal ligation)

PPN: Covered subject to the lesser of the PPN's charge or the applicable Cost Share.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable Cost Share.

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered subject to the lesser of the PPN's charge or the applicable Copayment and Plan Coinsurance for up to \$1,000 maximum per Member per calendar year after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable Copayment and at the Plan Coinsurance for up to \$1,000 maximum per Member per calendar year after the annual Deductible is satisfied.

- Lifetime benefit maximum

PPN and Community Provider benefit limits are combined and cannot be duplicated.

PPN: Covered up to \$5,000 per Member.

Community Provider: Covered up to \$5,000 per Member.

Tobacco Cessation

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

Covered in full.

- Approved pharmacy products

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

Section III. Eligibility, Enrollment and Termination

A. Eligibility

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

1. **Subscribers.** Bona fide employees who have been continuously employed on a regularly scheduled basis of not less than seventeen (17) hours per week shall be eligible for enrollment.
2. **Dependents.** The Subscriber may also enroll the following:
 - a. The Subscriber's legal spouse, including state-registered domestic partners as required by Washington state law;
 - b. Dependent children who are under the age of twenty-six (26).

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

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

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

B. Enrollment

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

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

- a. **Newly Eligible Persons.** Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible.
- b. **New Dependents.** A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within thirty-one (31) days after the dependency occurs.

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

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

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

- c. Open Enrollment.** GHO will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during a limited period of time specified by the Group and GHO.
- d. Special Enrollment.**
- 1) GHO will allow special enrollment for persons:
 - a) who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
 - cessation of employer contributions,
 - exhaustion of COBRA continuation coverage,
 - loss of eligibility, except for loss of eligibility for cause; or
 - b) who have had such other coverage exhausted because such person reached a Lifetime Maximum limit.

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

- 2) GHO will allow special enrollment for individuals who are eligible to be a Subscriber, his/her spouse and his/her Dependents in the event one of the following occurs:
 - marriage. Application for coverage under the Agreement must be made within thirty-one (31) days of the date of marriage.
 - birth. Application for coverage under the Agreement for the Subscriber and Dependents other than the newborn child must be made within sixty (60) days of the date of birth.
 - adoption or placement for adoption. Application for coverage under the Agreement for the Subscriber and Dependents other than the adopted child must be made within sixty (60) days of the adoption or placement for adoption.
 - eligibility for medical assistance: provided such person is otherwise eligible for coverage under this Agreement, when approved and requested in advance by the Department of Social and Health Services (DSHS).
 - applicable federal or state law or regulation otherwise provides for special enrollment.
- 2. Limitation on Enrollment.** The Agreement will be open for applications for enrollment as set forth in this Section III.B. Subject to prior approval by the Washington State Office of the Insurance Commissioner, GHO may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that GHO's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

C. Effective Date of Enrollment

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

- Enrollment for a newly eligible Subscriber hired between the 1st and the 15th of the month, and listed Dependents, is effective on the first (1st) of the following month, provided the Subscriber's application has been submitted to and approved by GHO. Enrollment for a newly eligible Subscriber hired between the 16th and the end of the month, and listed Dependents, is effective on the first (1st) of the second month following the date of hire, provided the Subscriber's application has been submitted to and approved by GHO.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first (1st) of the month following the date eligibility requirements are met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes total or partial financial support of the child.

2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above.

D. Eligibility for Medicare

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

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

E. Termination of Coverage

1. **Termination of Specific Members.** Individual Member coverage may be terminated for any of the following reasons:
 - a. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in Section III., and is not enrolled for continuation coverage as described in Section III.G. below, coverage under the Agreement will terminate at the end of the month during which the loss of eligibility occurs, unless otherwise specified by the Group.
 - b. **For Cause.** Coverage of a Member may be terminated upon ten (10) working days written notice for:
 - i. Material misrepresentation, fraud or omission of information in order to obtain coverage.
 - ii. Permitting the use of a GHO identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

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

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

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

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

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

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

F. Services After Termination of Agreement

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

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

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

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

G. Continuation of Coverage Options

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

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

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

- 3. Self-Payments During Labor Disputes.** In the event of suspension or termination of employee compensation due to a strike, lock-out or other labor dispute, a Subscriber may continue uninterrupted coverage under the Agreement through payment of monthly premiums directly to the Group. Coverage may be continued for the lesser of the term of the strike, lock-out or other labor dispute, or for six (6) months after the cessation of work.

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

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

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

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

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

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

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

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

Persons wishing to purchase GHO's Individual and Family coverage should contact Group Health Marketing.

Section IV. Schedule of Benefits

Benefits are subject to all provisions of the Group Medical Coverage Agreement, including, without limitation, the Accessing Care provisions and General Exclusions. Members must refer to Section II., the Allowances Schedule, for Cost Shares and specific benefit limits that apply to benefits listed in this Schedule

of Benefits. Members are entitled to receive only benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as described herein.

A. Hospital Care

The following hospital services are covered (1) under the PPN option when provided by the PPN, or (2) under the Community Provider option:

1. Room and board, including private room when prescribed, and general nursing services.
2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).
3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.
4. Drugs and medications administered during confinement.
5. Special duty nursing, when prescribed as Medically Necessary.

Members may not transfer to a PPN hospital during a nonemergent, scheduled admission to a non-PPN hospital. Coverage for Emergency care in a non-PPN Facility and subsequent transfer to a PPN Facility is set forth in Section IV.L.

B. Medical and Surgical Care

The following medical and surgical services are covered (1) under the PPN option when provided by a PPN Provider, or (2) under the Community Provider option when provided by a Community Provider:

1. Surgical services.
2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services.
3. Family planning counseling services.
4. Hearing examinations to determine hearing loss.
5. Blood and blood derivatives and their administration.
6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHO for the following:

PPN: Routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHO *and the Patient Protection and Affordable Care Act of 2010*, and immunizations and vaccinations listed as covered in the GHO drug formulary (approved drug list). Health education programs are covered as set forth in the Allowances Schedule. The well care schedule is available in Group Health clinics, by accessing GHO's website at www.ghc.org, or upon request.

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

Community Provider: Routine mammography screening, routine physical examinations for detection of disease and immunizations and vaccinations in accordance with the well care schedule established by GHO.

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

Excluded: internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by GHO.

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

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

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

12. Visits with providers, including consultations and second opinions, in the hospital or provider's office.
13. Optical services.

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

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

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

Community Provider: Routine eye examinations and refractions once every twelve (12) months, except when Medically Necessary. Routine eye examinations to monitor Medical Conditions are covered when Medically Necessary.

One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery, provided the Member has been continuously covered by GHO since such surgery.

Replacement of lenses for eye pathology, including following cataract surgery, will be covered only once within a twelve (12) month period when needed due to a change in the Member's Medical Condition.

Lenses and Frames

Benefits may be used toward the following in any combination, over the benefit period, until the benefit maximum is exhausted:

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

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

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

Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.

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

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

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

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

15. Transplant services.

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

- a. Evaluation testing to determine recipient candidacy,
- b. Matching tests,
- c. Inpatient and outpatient medical expenses listed below for transplantation procedures:
 - Hospital charges,
 - Procurement center fees,
 - Professional fees,
 - Travel costs for a surgical team, and
 - Excision fees

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

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

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

Community Provider: Not covered.

16. Manipulative therapy.

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

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

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

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

18. Diabetic training and education.

19. Detoxification services for alcoholism and drug abuse.

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

Coverage for acute chemical withdrawal is provided without prior approval. If a Member is hospitalized in a non-PPN Facility/program, coverage is subject to payment of the Emergency care Cost Share.

20. Circumcision.

21. Nutritional counseling provided by PPN staff.

22. Sterilization procedures.

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

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

24. Visits for covered *acupuncture and naturopathy*.

For coverage under the PPN option, Covered Services must be provided by a PPN Provider. Laboratory and radiology services are covered only when obtained through a PPN Facility.

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

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

26. Visits with licensed massage therapists to restore function immediately following illness, injury or surgery.

Covered Services *require a prescription from either a PPN or community physician and* must be provided by a PPN Provider *or Community Provider*.

Excluded: recreational, life-enhancing, relaxation or services designed to relieve or soothe symptoms of a disease or disorder without effecting a cure (palliative therapy), preventive care visits to massage therapists and any services not within the scope of their licensure.

27. *Injections administered by a professional in a clinical setting.*

C. Chemical Dependency Treatment.

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

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

Chemical dependency treatment services are covered as set forth in the Allowances Schedule (1) under the PPN option when provided at a PPN Facility or PPN-approved treatment program, or (2) under the Community Provider option when provided at an approved treatment facility.

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

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

Under the Community Provider option, non-Washington State alcoholism and/or drug abuse treatment service providers must meet the equivalent licensing and certification requirements established in the state where the provider's practice is located.

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

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

2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHO which has produced a major effect on the Member's appearance, when such services can reasonably be expected to correct the condition.
3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

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

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

Excluded: complications of noncovered surgical services.

- E. Home Health Care Services.** Home health care services, as set forth in this section, shall be covered (1) under the PPN option, when provided by PPN's Home Health Services or a PPN-authorized home health agency, or (2) under the Community Provider option, when provided by a State-licensed home health agency and prescribed by a Community Provider.

In order to be covered, the following criteria must be met:

1. The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.
2. The Member requires intermittent skilled home health care services, as described below.
3. A provider has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

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

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

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

- F. Hospice Care.** Hospice care, as set forth in this section, shall be covered (1) under the PPN option when provided by PPN's Hospice Program or a PPN-approved hospice agency, or (2) under the Community Provider option when provided by a licensed non-PPN hospice agency. Hospice care is covered in lieu of curative treatment for terminal illness for Members who meet all of the following criteria:

- A physician has determined that the Member's illness is terminal and life expectancy is six (6) months or less.
- The Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness).
- The Member has elected in writing to receive hospice care through a hospice program.

- The Member has available a primary care person who will be responsible for the Member's home care.
- A physician and the hospice agency have determined that the Member's illness can be appropriately managed in the home.

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

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

a. Home Services

- 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.
- Continuous care services in the Member's home when prescribed by a physician, as set forth in this paragraph. "Continuous care" means skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill Member at home. Continuous care may be provided for pain or symptom management by a Registered Nurse, Licensed Practical Nurse or Home Health Aide under the supervision of a Registered Nurse. Continuous care is covered up to twenty-four (24) hours per day during periods of crisis. Continuous care is covered only when a physician determines that the Member would otherwise require hospitalization in an acute care facility.

b. Inpatient Hospice Services. For short-term care, inpatient hospice services shall be covered according to the provisions set forth in Section IV.A.

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

c. Other covered hospice services may include the following:

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

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

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

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

G. Rehabilitation Services.

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

- a. All services **require a prescription from either a PPN or community physician** and **must be** provided by a PPN-approved **or Community Provider** rehabilitation team that may include medical, nursing, physical therapy, occupational therapy and speech therapy providers.
- b. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.
- c. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

Excluded: inpatient Residential Treatment services; specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy and speech therapy services when such services are available (whether application is made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member's level of functioning (except as set forth in subsection 2. below); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded under Section V.

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

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

H. Devices, Equipment and Supplies.

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

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

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

2. **Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.
3. **Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable medical equipment includes: hospital beds, wheelchairs,

walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHO, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.

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

Repair, adjustment or replacement of appliances and equipment is covered when Medically Necessary and appropriate.

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

I. Tobacco Cessation.

Services related to tobacco cessation are covered, limited to (1) participation in an individual or group program; (2) educational materials; and (3) approved pharmacy products provided the Member is actively participating in a GHO-designated tobacco cessation program.

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

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

Generic and brand name drugs and medicines must be listed as covered in the GHO drug formulary. Formulary and non-formulary drugs are covered as set forth in the Allowances Schedule. The prescription drug Cost Share, as set forth in the Allowances Schedule, applies to each thirty (30) day supply. Cost Shares for single and multiple thirty (30) day supplies of a given prescription are payable at the time of delivery. Injectables that can be self-administered are also subject to the prescription drug Cost Share. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by GHO.

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

"Standard reference compendia" means the American Hospital Formulary Service -- Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia -- Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services.

"Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications

in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Under the PPN option, all drugs, supplies, medicines and devices must be prescribed by a PPN Provider for conditions covered by the Agreement and obtained at a PPN pharmacy.

Under the Community Provider option, all drugs, supplies, medicines and devices must be obtained at a Contracted Network Pharmacy, except when a Contracted Network Pharmacy is not available within a thirty (30) mile radius or for drugs dispensed by a provider for Emergency care.

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; and vitamins, including Legend (prescription) vitamins.

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

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

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

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

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

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

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

Under the Community Provider option, outpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24); a master's level therapist (certified under RCW 18.19), an advanced practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.

2. Inpatient Services. Charges for services described in this section, including psychiatric Emergencies resulting in inpatient services, are covered as set forth in the Allowances Schedule. This benefit shall include coverage for acute treatment and stabilization of psychiatric Emergencies provided in a (a) PPN-approved hospital under the PPN option, and (b) hospital or facility approved specifically for treatment of mental or nervous disorders under the Community Provider option. When medically indicated, outpatient electro-convulsive therapy (ECT) is covered in lieu of inpatient services.

Services provided under involuntary commitment statutes shall be covered at facilities approved by GHO. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary.

Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit set forth in Section IV.L.

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

Under the Community Provider option, inpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24); a master's level therapist (certified under RCW 18.19), an advanced practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.

3. **Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.** Covered Services are limited to those authorized for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention.

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

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

L. Emergency/Urgent Care.

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

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

1. **At a PPN Facility.** GHO will cover Emergency care for all Covered Services.

Inpatient Emergency care received at a PPN Facility is also subject to:

- a. Transfer of care to a PPN Provider; and
- b. Transfer to another PPN Facility if transferability is medically possible as determined by the PPN.

2. **At a Non-PPN Facility.** Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to payment of the Emergency care Cost Share.

3. **Waiver of Emergency Care Cost Share.**

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

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

4. Transfer and Follow-up Care. If a Member is hospitalized in a non-PPN Facility, GHO reserves the right to transfer the Member to a PPN Facility, upon consultation between a PPN Provider and the attending physician.

Under the PPN option, follow-up care which is a direct result of the Emergency must be received from PPN Providers. Follow-up care for services received under the Community Provider option, that is a direct result of the Emergency, is covered subject to the Cost Shares set forth in the Allowances Schedule.

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

Under the PPN option, care for Urgent Conditions is covered at PPN medical centers, PPN urgent care clinics or PPN Providers' offices, subject to the applicable Cost Share.

Under the Community Provider option, charges for Urgent Conditions received at any medical facility are covered subject to the applicable Cost Share.

M. Ambulance Services.

1. Emergency Transport to any Facility. Each Emergency is covered as set forth in the Allowances Schedule. Ambulance services under the PPN option are covered provided that the service meets the definition of an Emergency (see Section VIII.).

2. Interfacility Transfers.

a. PPN-Initiated Transfers. PPN-initiated non-emergent transfers to or from a PPN Facility are covered as set forth in the Allowances Schedule.

b. Community Provider-Initiated Transfers. When prescribed by the attending physician, transport from a medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered as set forth in the Allowances Schedule.

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

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

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

Section V. General Exclusions

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

1. Services or supplies not specifically listed as covered in the Schedule of Benefits, Section IV, not Medically Necessary and, in the case of out of network services, not Usual, Customary and Reasonable.
2. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; take-home drugs, dressings and supplies following

hospitalization; and any other supplies, dressings, appliances, devices or services which are not specifically listed as covered in Section IV.

3. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided in Section IV.D.
4. Convalescent or custodial care.
5. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.E., IV.F. or IV.H.
6. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.
7. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHO for early detection of disease.
8. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.
9. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.
10. Any services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

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

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

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

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

11. Late term pregnancy termination except when the health of the mother is at risk.
12. The cost of services and supplies resulting from a Member's loss of or willful damage to appliances, devices, supplies and materials covered by GHO for the treatment of disease, injury or illness.
13. Orthoptic therapy (i.e., eye training).
14. Specialty treatment programs such as weight reduction, "behavior modification programs" and rehabilitation, including cardiac rehabilitation.
15. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.
16. Procedures and services to reverse a therapeutic or nontherapeutic sterilization.
17. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental service not specifically listed as covered in Section IV. GHO will determine whether the care or treatment required is within the category of dental care or service.
18. Drugs, medicines and injectables, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injectables, including those not listed as covered in the GHO drug formulary (approved drug list), will also exclude their administration.
19. Experimental or investigational services.

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

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

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

Appeals regarding *GHO* denial of coverage can be submitted to the Member Appeal Department at P.O. Box 34593, Seattle, WA 98124-1593.

- 20. Chemical dependency, rehabilitation services and mental health care, except as specifically provided in Sections IV.C., IV.G. and IV.K.
- 21. Hypnotherapy, and all services related to hypnotherapy.
- 22. Genetic testing and related services, unless determined Medically Necessary, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in Section IV.B. Testing for non-Members is also excluded.
- 23. Follow-up visits related to a non-Covered Service.
- 24. Fetal ultrasound in the absence of medical indications.
- 25. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.
- 26. Complications of non-Covered Services.
- 27. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth in Section IV.B.
- 28. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a member of the Member's family.
- 29. Autopsy and associated expenses.
- 30. Services provided by government agencies, except as required by federal or state law.
- 31. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.
- 32. Services covered by the national health plan of any other country.
- 33. Pre-Existing Conditions, except as specifically provided in Section IV.B.25.

Section VI. Grievance Processes for Complaints and Appeals

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

Filing a Complaint or Appeal

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

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

Complaint Process

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

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

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

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

Appeals Process

Initial Appeal

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

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

There is an expedited appeals process in place for cases which meet criteria or where the Member's provider believes that the standard appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited appeal in writing to the above address, or by calling GHO's Member Appeal Department toll free (866) 458-5479. The Member's request for an expedited appeal will be processed and a decision issued no later than *twenty-four (24) hours* after receipt of *sufficient information to determine whether, or to what extent, benefits are covered or payable under the Agreement.*

Next Level of Appeal

If the Member is not satisfied with the decision regarding a GHO denial of benefits, or if GHO fails to *adhere to the requirements of the appeals process, the Member* may request a second level review by an external independent review organization as set forth under subsection A. below. The Member may also choose to pursue review by an

appeal committee prior to requesting a review by an independent review organization as set forth under subsection B. below. This is not a required step in the appeals process.

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

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

- B. Request an optional hearing by the GHO appeal committee:

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

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

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

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

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

Section VII. General Provisions

A. Coordination of Benefits

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

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

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

1. Definitions.

- a. **Plan.** A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a Group, the separate contracts are considered parts of the same plan and there is no COB among those separate

contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

- 1) Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- 2) Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

- b. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- c. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Member has health care coverage under more than one plan.

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

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

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

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

- 3) If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 - 4) An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.
- e. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
 - f. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

2. Order of Benefit Determination Rules.

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

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

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

- c. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- d. Each plan determines its order of benefits using the first of the following rules that apply:
 - 1) Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the Member as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent, and primary to the plan covering the Member as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.
 - 2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
 - (2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - (3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;
 - (4) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits; or
 - (5) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan covering the custodial parent, first;
 - The plan covering the spouse of the custodial parent, second;
 - The plan covering the non-custodial parent, third; and then
 - The plan covering the spouse of the non-custodial parent, last.
 - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection a) or b) above determine the order of benefits as if those individuals were the parents of the child.
- 3) Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.
 - 4) COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Subscriber or retiree or covering the Member as a Dependent of an employee, member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section d 1) can determine the order of benefits.
 - 5) Longer or shorter length of coverage. The plan that covered the Member as an employee, member, Subscriber or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.
 - 6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

3. Effect on the Benefits of this Plan.

When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be

required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Member be responsible for a deductible amount greater than the highest of the two deductibles. Total allowable expense is the highest allowable expenses of the primary plan or the secondary plan. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

4. Right to Receive and Release Needed Information.

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

6. Right of Recovery.

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

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

7. Effect of Medicare.

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

- a. When the PPN renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, GHO will seek Medicare reimbursement for all Medicare covered services.
- b. When a Member, who is a Medicare beneficiary and for whom Medicare has been determined to be the primary bill payer under Medicare secondary payer guidelines and regulations, seeks care from Community Providers, GHO has no obligation to provide any benefits except as specifically outlined in the Community Provider option under Section IV.

B. Subrogation and Reimbursement Rights

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

"Injured Person" under this section means a Member covered by the Agreement who sustains an injury and any spouse, dependent or other person or entity that may recover on behalf of such Member including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this

section, "GHO's Medical Expenses" means the expenses incurred and the value of the benefits provided by GHO ***under this Agreement*** for the care or treatment of the injury sustained by the Injured Person.

If the Injured Person's injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party and the Injured Person, GHO shall have the right to recover GHO'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." GHO shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHO's Medical Expenses.

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

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorist funds, then GHO's Medical Expenses provided or to be provided to the Injured Person are secondary, not primary. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHO services is constructive notice of this provision in its entirety and agrees to reimburse GHO 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 GHO in its efforts to collect GHO's Medical Expenses. This cooperation includes, but is not limited to, supplying GHO with information about ***the cause of injury or illness***, any third parties, defendants and/or insurers related to the Injured Person's claim and informing GHO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHO, at GHO'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 GHO to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHO's Medical Expenses.

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

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

If this Agreement is subject to ERISA and reasonable collections costs have been incurred by the Injured Person for the benefit of GHO, the Injured Person may request and GHO may reduce the amount of reimbursement to GHO by an amount for reasonable and necessary attorney's fees incurred by the Injured

Person on behalf of and for the benefit of GHO, but only if such amount is agreed to by GHO prior to settlement or recovery.

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

C. Miscellaneous Provisions

1. **Identification Cards.** GHO will furnish cards, for identification purposes only, to all Members enrolled under the Agreement.
2. **Administration of Agreement.** GHO may adopt reasonable policies and procedures to help in the administration of the Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.
3. **Modification of Agreement.** No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of the Agreement, convey or void any coverage, increase or reduce any benefits under the Agreement or be used in the prosecution or defense of a claim under the Agreement.
4. **Confidentiality.** GHO and the Group shall keep Member information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.
5. **Nondiscrimination.** GHO does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

D. Utilization Management

All benefits under the Agreement are limited to Covered Services that are Medically Necessary and set forth in Section IV. GHO may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, GHO may deny coverage if, in its determination, such services are not Medically Necessary and in the case of out of network services, Usual, Customary and Reasonable. Such determination shall be based on established clinical criteria.

GHO will not deny coverage retroactively for services it has previously authorized and which have already been provided to the Member.

Benefits under the Agreement do not require preauthorization, except as otherwise noted under Section IV.

Section VIII. Definitions

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

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

Community Provider: Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.79 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, podiatrists licensed under 18.22 RCW or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's

practice is located. For purposes of the Agreement, Community Providers do not include individuals employed by or under contract with the PPN or who provide a service or treat Members outside the scope of their licenses.

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

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

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

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

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

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

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

Essential Health Benefits: Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Family Unit: A Subscriber and all his/her Dependents.

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

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

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 provider, be provided by a nursing home or convalescent care center.

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

Medical Condition: A disease, illness or injury.

Medically Necessary: Appropriate and clinically necessary services, as determined by GHO's Medical Director, or his/her designee, according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In

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

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

Member: Any Subscriber or Dependent enrolled under the Agreement.

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

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

Plan Coinsurance: The percentage amount the Member and GHO are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule. *A coinsurance percentage not identified as Plan Coinsurance is a benefit specific coinsurance and does not apply to the Out-of-Pocket Limit except as otherwise noted under Section II. Out-of-Pocket Limit.*

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

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

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

Preferred Provider Network (PPN): The participating provider with which GHO has entered into a written participating provider agreement for the provision of Covered Services.

Residential Treatment: A term used to define facility-based treatment, which includes twenty-four (24) hours per day, seven (7) days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.

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 GHO.

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

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

Usual, Customary and Reasonable (UCR): Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Amounts charged by a Community Provider in excess of UCR rates are the responsibility of the Subscriber and/or Member.