



BASIC HEALTH

member guide



GroupHealth®

CONTENTS

The Basics of Your Plan	2
Benefits and Services	4
A Quick Start to Primary Care	8
All About Specialty Care	10
Group Health Physicians	10
Group Health—contracted Specialists	10
Behavioral Health Care	10
Midwifery Services	11
Pediatric and Teen Health Care	11
Women’s Health Care	11
Urgent Care, Emergencies, and Hospitalization	12
24-Hour Consulting Nurse Helpline	12
Urgent Care	12
Emergencies	13
Hospitalization	14
Prescriptions	16
Online Services: MyGroupHealth for Members	18
Perks for Members	20
Additional Plan Information	22
Group Health Rights and Responsibilities	24
Basic Health Rights, Responsibilities and Privacy	27
Basic Health Grievances and Appeals	30
Limitations and Exclusions	34
What Is Not Covered	37
The Health Coverage Tax Credit Program	39
Contact Information	back cover

GROUP HEALTH IS A SMOKE-FREE ENVIRONMENT

To demonstrate our national and community leadership role in health promotion and wellness, smoking and all tobacco use are prohibited on all Group Health property—including both building interiors and on the facility grounds. Smoking and all tobacco use are also prohibited on or in any property owned or leased by Group Health (including vehicles).



THE BASICS OF YOUR PLAN

Welcome

Welcome to the Basic Health plan offered by Group Health Cooperative. We are delighted to have you as a member and look forward to helping you live your healthiest life.

This guide is designed to help you understand your plan and how to access your care. It's broken up into snapshots of the care you might receive: primary care, specialty care, urgent care, emergencies, hospitalization, and prescriptions. We've also outlined the valuable online services that give you more control of your health care than ever before, the additional special member services, additional plan information, and your rights and responsibilities as a member.

If you still have questions after you read this guide, please call Customer Service for more information.

Providers

The online provider directory lists all the providers that are available to you as a Basic Health member. Just go to **ghc.org**

Identification card

You and each member of your family will soon receive an identification (ID) card with an individual member number. Have your ID card with you to make, cancel, or check appointments; order or pick up prescriptions; or to use the Consulting Nurse helpline. Call Customer Service if any covered family member does not receive a card, if any information on the card is wrong, if it's lost or stolen, or if it needs to be replaced.

GROUP HEALTH CONVENIENCE

Group Health Cooperative owns medical centers and facilities throughout Washington. When you get your care at Group Health Medical Centers locations, getting the most from your health plan becomes a lot easier. Your personal physician, the lab, X-ray, and pharmacy are all in one location. So driving around town is now a thing of the past.



Benefits and services subject to the deductible and coinsurance

All benefits and services with a coinsurance are subject to a \$250 annual deductible. Once you meet your \$250 deductible, your health plan pays the 80 percent coinsurance and you pay 20 percent. All coinsurance payments that you make will be applied toward your \$1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the \$1,500 per person out-of-pocket maximum has been reached, the health plan pays the coinsurance in full for all covered benefits and services.

If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

BENEFIT* / SERVICE	MEMBER'S PAYMENT RESPONSIBILITY	DESCRIPTION
HOSPITAL, INPATIENT	20% coinsurance; deductible applies. \$300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charge for maternity services or readmission for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services. See "Other Professional Services" below.
HOSPITAL, OUTPATIENT	20% coinsurance; deductible applies.	
OTHER PROFESSIONAL SERVICES	20% coinsurance; deductible applies.	Services received as an inpatient include, but are not limited to: surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
MENTAL HEALTH	20% coinsurance; deductible applies to inpatient. \$300 maximum facility charge per admittance.	Facility charges may include, but are not limited to: room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. Outpatient visits are subject to \$15 copayment (see Office Visits).
LABORATORY	No copayment or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.

BENEFIT* / SERVICE	MEMBER'S PAYMENT RESPONSIBILITY	DESCRIPTION
RADIOLOGY	20% coinsurance, except for outpatient X-ray and ultrasound.	Deductible applies to services with coinsurance.
AMBULANCE SERVICES	20% coinsurance; deductible applies.	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
CHIROPRACTIC/ PHYSICAL THERAPY/ OCCUPATIONAL THERAPY	20% coinsurance; deductible applies.	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as postoperative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
CHEMICAL DEPENDENCY	20% coinsurance and deductible apply to inpatient services. \$300 maximum facility charge per admittance.	Limited to \$5,000 every 24-month period; \$10,000 lifetime maximum. Outpatient visits are subject to \$15 copayment (see "Office Visits").
ORGAN TRANSPLANTS	Deductible, coinsurance, and copayments apply by specific service.	12-month waiting period, except for children up to age 19.

*Benefits for Health Coverage Tax Credit (HCTC) members may differ. Please call Customer Service at **1-888-901-4636** for further details.

Benefits and services not subject to the deductible and coinsurance

The \$250 annual deductible and \$1,500 out-of-pocket maximum per person, per calendar year do not apply to the following benefits and services.

BENEFIT* / SERVICE	MEMBER'S PAYMENT RESPONSIBILITY	DESCRIPTION
PREVENTIVE CARE	No copayment.	Includes routine physicals, Pap tests, immunizations, mammograms, and other screening and testing when provided as part of the preventive care visit.
OFFICE VISITS	\$15 copayment.	Copayment is for office visit only and includes consultations, mental health, and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
PHARMACY**		30-day supply
TIER 1	\$10 copayment (or cost of drug, whichever is less).	Tier 1 includes generic drugs in health plan's preferred drug list (formulary).
TIER 2	50% of the drug cost.	Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
EMERGENCY ROOM VISIT	\$100 copayment.	No copayment if admitted; hospital coinsurance and deductible would apply.
OUT-OF-AREA EMERGENCY SERVICES	\$100 copayment.	No copayment if admitted; hospital coinsurance and deductible would apply.
URGENT CARE	\$15 copayment.	Copayment is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
SKILLED NURSING, HOSPICE, AND HOME HEALTH CARE	No copayment.	Covered as an alternative to hospital care at the health plan's discretion.
MATERNITY CARE	No copayment.	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.
OXYGEN	No copayment.	Includes equipment and supplies. Not subject to copays, coinsurance, or deductible. Requires health plan authorization.

*Benefits for Health Coverage Tax Credit (HCTC) members may differ. Please call Customer Service at **1-888-901-4636** for further details.

Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, call Customer Service at **1-888-901-4636.



Step 1: Choose a personal physician

The first step in your plan to get or stay well is to select a personal physician. Choosing a personal physician is important because your doctor helps guide your total health care program. From arranging your laboratory tests, X-rays, and hospital care, to writing prescriptions, referring you to certain specialists if necessary, physical therapy, and more, your doctor is your partner in keeping you in the best of health. And each member of your family can choose their own physician in order to start developing strong, healthy relationships.

When you choose a doctor, it helps if you inform Customer Service of your physician choice. You can change your personal physician for any reason, just contact Customer Service.

To choose a provider, do one of the following:

- Choose a doctor from the online provider directory at **ghc.org** and notify Group Health Customer Service of your physician choice
- Call Group Health Customer Service for help in making a selection

If you don't select a provider through Customer Service, you will receive a letter in the mail giving you the name of the personal physician we have selected for you. You can change your personal physician at any time by calling Customer Service.

MYGROUPHEALTH FOR MEMBERS

Group Health Medical Centers primary care gives you access to the full breadth of services and information available to you on MyGroupHealth for Members at **ghc.org**. For more information on these valuable services, visit the chapter in this guide entitled "Online services for members" on page 18.

Step 2: Make an appointment

When you need medical care, making an appointment is easy once you have selected your personal physician. All you need to do is call your doctor's office or go online to ghc.org and make the request.

There are a few things to do to prepare for your visit. Write down any questions or concerns so you can be sure to remember them when the time comes. Be ready to describe your symptoms and bring the names of any medicine you're taking. Also, remember to take your ID card with you.

When you're with your doctor, remember to tell him or her about any treatment you are receiving from other doctors, and be sure you understand any medical instructions he or she gives you. If you have any questions, it's a good idea to ask your doctor before you leave the office.

Whenever you travel outside the Group Health service area, you can make an appointment at any of Kaiser Permanente's nationwide facilities and receive care at your regular level of coverage. However, some services will require preauthorization from Group Health. Call Customer Service if you have questions about this benefit or about preauthorization.

Step 3: Plan for your cost share

When it's time for your appointment, be prepared to pay your cost share. Your portion may include a copayment, coinsurance, or your deductible.

SAME-DAY APPOINTMENTS

Group Health strives to offer you same-day appointments. If you get care at a Group Health Medical Centers location, call your doctor's office in the morning and there's a good chance you can see your physician or a member of the medical team that very day.

Specialty care

Access to some specialty care providers is dependent upon whether you choose a provider with Group Health Physicians or other contracted community providers for your primary care, and may be limited to consulting specialists who are used by your personal physician or other attending physicians. If you have questions about the referral process or about which consulting specialist your personal doctor uses, please contact your doctor or call Customer Service.

Group Health Physicians

You can get specialty care from many Group Health Physicians specialists without a referral by calling the specialist's office directly or Customer Service. Specialists are listed online at **ghc.org** and in the provider directory.

Group Health–contracted specialists

For specialty care from doctors who contract with Group Health and do not practice with Group Health Physicians, talk with your personal physician. A referral is required from your personal doctor before seeing these contracted specialists.

Behavioral health care (mental health and chemical dependency)

Please see the Benefits and Services table on page 4. While you do not need a referral from your personal physician to get these services, Behavioral Health Services coordinates and authorizes all mental health and chemical dependency care for Group Health members.

If you are a first-time patient, please call the Behavioral Health Unit at this statewide toll-free number: **1-888-287-2680**.

WELLNESS

We're big on preventive care—and we place an emphasis on staying well. As you read this booklet, you'll discover all the ways we try to help you do just that. And because of our commitment to your good health, you're covered for preventive care services including Lifestyle Coaching, immunizations, and a range of health screenings for you and your family.

Midwifery services

The Group Health network includes certified nurse-midwives who are registered nurses accredited in midwifery by the American College of Nurse-Midwives. Each meets state licensing requirements and has passed a national examination. Nurse-midwives focus on education and health care for women and their families, providing complete maternity care to women experiencing normal pregnancies. Each has hospital privileges and works in collaboration with the patient's personal physician to ensure continuity of care. To select a contracted midwife, see your provider directory, visit ghc.org, or call Customer Service.

Pediatric and teen health care

Your child is covered, from regular checkups to immunizations, and you can select a pediatrician as your child's personal physician. Group Health also contracts with several community facilities that specialize in pediatric care.

Teen health care needs are unique, so young adults can schedule their own appointments and see a physician for all kinds of health and well-being issues. Call Customer Service for more information.

If your child is covered under the Basic Health Plus program, please call Customer Service to receive a Healthy Options/Basic Health Plus/State Children's Health Insurance Program (SCHIP) Member Guide.

Women's health care

Women can self-refer for reproductive health care, gynecological care, maternity care, and general preventive care, such as Pap smears and breast exams. Group Health also offers the Family Beginnings Birthing Center on the Capitol Hill Campus in Seattle. In other parts of the state there are many local hospitals in the network to provide convenient birthing services for members.

24-hour Consulting Nurse helpline

The Consulting Nurse helpline is available 24 hours a day. Group Health's team of experienced registered nurses and pharmacists are specially trained to answer your medical questions, provide care advice, and advise you whether or not you should see a doctor. There is also a doctor on staff working directly with the Consulting Nurse Service. What's more, if you get your care at a Group Health Medical Centers location or hospital, the Consulting Nurse Service staff has access to portions of your medical history and prescriptions, so they can better advise you on what's best for your personal situation. Just call **1-800-297-6877** or **206-901-2244**.

Urgent care

An urgent care situation is one that does not pose an immediate, serious health threat, but does require prompt medical attention within 24 hours of its onset. Some conditions that might be urgent are:

- Stomach or abdominal pain
- Urinary tract infections
- Cuts that might require stitches
- Minor injuries such as sprains
- Respiratory infections

For urgent care during the day, call your personal physician's office or the Consulting Nurse helpline to get immediate advice. The Consulting Nurse will direct you to the nearest facility, if necessary.

For urgent care after business hours, on weekends, or on holidays, call the Consulting Nurse helpline for assistance. The consulting nurse will direct you to the nearest facility, if necessary.

IMPORTANT COVERAGE NOTE

If you receive urgent or emergency care at a nonparticipating hospital or medical center, you may be required to pay in full at the time of service. If so, save your medical receipts and we'll reimburse you for covered services.

Also, if you use an emergency room for nonemergency services, Group Health will not cover your care. You will be fully responsible for any costs.

Emergencies

Emergency medical conditions include those that make you feel you need immediate medical attention to avoid a serious threat to your body or your health. These conditions may include:

- Severe pain
- Suspected heart attack or stroke
- Sudden or extended difficulty in breathing
- Bleeding that will not stop
- Major burns
- Seizures
- Sudden onset of severe headache
- Suspected poisoning

If you're having an emergency, get care immediately. Call **911** or your local emergency number. And if you're traveling, remember to find out the emergency number for the region where you're traveling throughout the world, as it's not always **911**.

If you are admitted to a nonparticipating facility in an emergency, you or a family member must call the Notification Line within 24 hours or as soon thereafter as is reasonably possible following the emergency. The statewide Notification Line number is **1-888-457-9516**. This number is also found on the back of your member ID card.

Also, emergency ambulance service to a Group Health facility is a covered benefit. Nonemergency ambulance service must be authorized in advance by your personal physician.

Check your Benefit and Service table on pages 5 and 6 to find out about your costs for emergency and ambulance services. Emergency services are only covered when they meet the definition of an emergency. For a definition, please see your Basic Health Member Handbook.

URGENT AND EMERGENCY CARE WITH KAISER PERMANENTE

Access to any of Kaiser Permanente's nationwide facilities is at your level of coverage and includes routine care as well as urgent or emergency care. However, some services will require preauthorization from Group Health. Call Customer Service for more information.

Hospitalization

If you need to be admitted to a hospital, your personal physician will refer you to a Group Health–participating facility. Care received at the numerous participating hospitals affords you the lowest out-of-pocket costs. These are listed in your online provider directory at **ghc.org**. Following is a sampling of the major participating hospitals and medical centers:

In Western Washington

- Group Health Central Hospital on the Group Health Capitol Hill Campus in Seattle
- Overlake Hospital Medical Center in Bellevue
- Virginia Mason Medical Center in Seattle
- St. Joseph Medical Center in Tacoma
- St. Joseph Hospital in Bellingham
- Providence St. Peter Hospital in Olympia
- Providence Everett Medical Center

In Eastern Washington

- Valley Hospital and Medical Center in Spokane
- Sacred Heart Medical Center in Spokane
- Kennewick General Hospital in Tri-Cities
- Yakima Valley Memorial Hospital
- Lourdes Medical Center in Pasco

As a Basic Health member, you can get care in the Group Health service area at these hospitals, as well as at numerous other participating hospitals throughout the state. These are all listed in the online Basic Health provider directory at **ghc.org**

If you are admitted to a nonparticipating facility in an emergency, you or a family member must call the Notification Line within 24 hours or as soon thereafter as is reasonably possible following the emergency. After your situation is under control and you have called the Notification Line, your personal physician may be contacted if you require follow-up care. The statewide Notification Line number is **1-888-457-9516**. This number is also found on the back of your ID card for easy reference.

GROUP HEALTH MEANS CARE AND CONSIDERATION

“Group Health means care and consideration when going through a major medical crisis in your life. It means knowing someone is there to look out for your interests. They have the patient in mind first and make sure they get the care they need.”

–Sonya Franck,
member



What's covered

Please see the Benefits and Services table on page 6. Group Health Cooperative has a list of medications (called a formulary) that are covered through your plan with a cost share. The formulary includes both generic and certain brand-name drugs. In most cases, we cover only medications on the formulary. However, if your physician determines that you need a particular medication for certain conditions or a drug that is not on the list, your physician will have the request reviewed to determine if the drug can be covered.

You can get a copy of the formulary by calling Customer Service. To check whether your drug is on the formulary, visit ghc.org

What's not covered

- Nonprescription or over-the-counter medicines, drugs for cosmetic uses, or travel medications (for motion sickness and/or diarrhea)
- Dental prescriptions (unless prescribed by your provider for a medical condition)
- Drugs used for reasons not approved by the FDA
- Plan-excluded prescription drugs

Filling your prescriptions

Any prescription from a doctor can be filled at any Group Health Medical Centers locations or hospital pharmacy or at any of Group Health's network pharmacies (pharmacies that Group Health contracts with, but does not operate). There's a pharmacy in all Group Health Medical Centers locations for your convenience. If you want a complete list of all the Group Health and Group Health-network pharmacies, go online to ghc.org

If you need a new prescription when your regular pharmacy is closed, you should make every effort to fill the prescription at another participating pharmacy. If this is not possible, you can fill the prescription at the pharmacy of your choice at your expense and submit a claim for reimbursement. Group Health will not reimburse refills or medications for chronic conditions as emergency prescriptions when they can be filled during normal business hours.

Depending on the medication you need, prescriptions will be filled for a 90-day or a 30-day supply at one time at Group Health pharmacies and at participating contracted pharmacies. And remember to plan ahead when you travel. Be sure to take enough medicine to cover the duration of your trip. Ask for up to a 90-day supply if you need it. Travel medications (for diarrhea and/or motion sickness) are generally not covered.

Get refills delivered to you

You can have your refills mailed to your home with no shipping or handling fee. Be sure to plan ahead if you use this service. If you get your prescriptions filled at non-Group Health Medical Centers pharmacies, you will need to transfer your prescription into the Group Health system in order to get your refills mailed to you. Transferring your prescription is easy—just visit **ghc.org** where you'll find the necessary transfer form. Deliveries can take up to 10 days, although in most cases, they arrive sooner. There are several ways to receive your prescription refills at home.

Online

Register with MyGroupHealth for Members at **ghc.org** and then complete a one-time ID verification process. Once you're registered, log in to MyGroupHealth for Members then go to the Pharmacy Online page.

Mail or fax

Call the Group Health Mail-Order Pharmacy Service for a mail-order request form, include a check or your credit card information, and drop the form in the mail. To fax, complete a mail-order request form and fax the form to **206-901-4443**.

Phone

Call the Group Health Mail-Order Pharmacy Service 24 hours a day to order refills. When you call, have your prescription number (the 11-digit number on the label), your member ID number, and your credit card handy. Call Pharmacy Service at **206-901-4444**, or toll-free at **1-800-245-7979**.

Questions?

If your prescription was written by a doctor with Group Health Physicians, call to speak to a staff pharmacist. Hours are from 7:30 a.m. to 6 p.m., Monday through Friday, and from 9 a.m. to 1 p.m. on Saturday.

If your prescription was written by a contracted community doctor, contact the pharmacy where your prescription was filled.

If you have questions about the formulary, coverage, or drug costs, please call Customer Service.

CHECK YOUR MEDS

If you are a new patient, you may be taking medicine prescribed by a different doctor. Please make an appointment to review your medicines with your new personal physician. Any prescription medicine you have been taking before seeing your new physician should be reviewed. Because health care needs change, checking your current prescription program will help ensure you're taking the right medicine to stay in the best of health. If you are allergic to any drugs, be sure to tell your new personal physician. This important information will be recorded in your medical record.

MyGroupHealth for Members

Group Health members benefit from a very useful resource: MyGroupHealth for Members at ghc.org. MyGroupHealth for Members gives you access to online health information, tools, and services that make health care accessible and convenient, 24 hours a day from the comfort of your home or office.

There are two levels of service on MyGroupHealth for Members: basic and enhanced. Basic services are available to all Group Health members, regardless of where you receive your primary care. And basic services are easy to access—you'll just need to register online and complete a one-time ID verification process. When you register, you'll only need to provide your name, Group Health member ID number, and birth date. To use our enhanced online services you will need to complete an additional one-time process to verify your identity. This helps protect the privacy of your personal medical information. (Once you register, you'll find additional instructions on how to upgrade your account to get access to the enhanced services. Some enhanced services are only available to members receiving Group Health Medical Centers primary care.)

Basic services

Choose a doctor

Use the online provider directory to get information on primary care and specialty doctors and other health care providers, then choose or change your personal primary physician online.

Healthwise® Knowledgebase

Get access to health information on thousands of topics, including a searchable database of articles on diseases, conditions, medications, and medical tests.

Health and wellness resources

Our health information includes in-depth articles, classes, interactive tools, and videos about treatment options. Check out the seasonal topics.

Enhanced services

Refill prescriptions

Order and pay for Group Health prescription refills online, view your current medications list, and get access to a database of drug information. You can even refill prescriptions for other members of your family.

E-mail your health care team*

Have a follow-up question for your doctor? Contact your Group Health Physicians team, the Consulting Nurse helpline, or other members of your health care team using this secure messaging service. You'll get a reply in your MyGroupHealth inbox by the end of the next business day.

CUSTOMER SERVICE— ONLINE AND BY PHONE

In addition to calling Customer Service, you can ask questions via e-mail. Just go to ghc.org and click on "Contact Us." You can request a new ID card, get coverage information, submit a compliment, and much more. Generally, you'll receive an e-mail response within 24 hours.

Parental access*

Get access to your child's online medical record through age 12. And for nonurgent issues, you can e-mail your child's doctor and request appointments. After your account is enhanced, fill out the "Request for Parental Access" form at the business desk in your medical center. Parents need to show a picture ID; other guardians must have documents showing they have legal authority to make health care decisions for a child.

Schedule appointments*

You can schedule an appointment with your personal physician, specialists, or other members of your health care team. Go online and suggest days and times that are convenient for you; you'll get a confirmation by the end of the next business day.

Your online medical record*

Get access to your online medical record including after-visit summaries, lab and test results, a list of your medications, your immunizations and allergies, your current health conditions, and patient discharge instructions from an emergency or urgent care visit at Group Health.

Your Health Profile

The Health Profile is an assessment to help you take better control of your health. After you complete the online questionnaire, you'll receive a personal report with suggestions on how to improve your health and lower your risk of certain diseases and conditions.

Your health coverage

Your summary of benefits and coverage agreement are available online for easy reference. You can also check how individual health plan claims were paid by viewing your Explanation of Benefits statements online.

Usage status

Get quick access to your annual deductible status, out-of-pocket expenses, and lifetime maximum cost shares for the past two years of membership with Group Health.

*Available only to members who receive their primary care at Group Health Medical Centers locations.

PERKS FOR MEMBERS

These special services are free:

Group Health Resource Line

The Group Health Resource Line offers free information on health education, community resources, senior services, and support groups in your area. Statewide, call **1-800-992-2279** or e-mail us at **resource.l@ghc.org**

Health improvement classes and services

Group Health offers a wide variety of educational resources on prenatal and baby care, diabetes, heart care, substance abuse, AIDS, and violence prevention. Go to **ghc.org** and click on “Classes & Events” to see what’s offered in your area.

Language interpreters

If you or someone you know needs professional language assistance, please call Customer Service. This service is provided at no extra cost.

Lifestyle Coaching

Take the online Health Profile at **ghc.org** and depending on your answers, and whether or not you provide your phone number, a Lifestyle Coach may contact you. A coach can help you make positive changes in your eating habits, physical activity, tobacco use, or how you cope with stress. The coaches are health care professionals, such as nurses and dietitians, who are trained in helping people make behavior changes. Through ongoing phone conversations, a coach can help you stay on track and reach your own health goals.

Northwest Health magazine

Northwest Health is mailed to your home four times a year and features health information to help you make healthy choices in your everyday living. It also provides information about changes in service hours and telephone numbers, new benefits, and health care programs through Group Health Cooperative.

Speech, Language & Learning Services

Group Health staff at Speech, Language & Learning Services treat a wide variety of communication and learning problems. These include language delay, language and learning disabilities, stuttering, impairment due to head injury, cognitive changes, and problems with study and social skills. Not all services are covered. For more information and locations, call **1-800-645-6799**. (Not available in Eastern Washington. Call Customer Service for assistance.)

GROUP HEALTH RESEARCH INSTITUTE

Your health and that of the greater community is the focus of the Group Health Research Institute (GHRI). Founded in 1983 as the Center for Health Studies, GHRI is a leader in health research and is nationally known for its work in cancer prevention, depression, back pain, elder health, injury prevention, and cardiovascular care. As a result of the researchers’ studies, the latest information on health issues from prevention to treatment helps members like you.

The Take Care Store

Purchase noncovered self-care and wellness products such as back support cushions, blood pressure monitors, and allergenic-control bedding at the Take Care Store, online at **take-care.com**. Additionally, a sampling of self-care products is available at kiosks found in all Group Health Medical Centers locations.

Travel Advisory Service

If you plan to travel or study outside the United States, you can use the Group Health Travel Advisory Service to learn what immunizations you'll need. The service will send you a packet with information about each country that you plan to visit, including travel advisories. Call **206-326-3488**.

These special services are not free:

Accomplish™ Weight Management Program

The Accomplish™ Weight Management Program is a total lifestyle program, teaching the development of positive behaviors that promote healthy living, and helping to improve overall well-being through weight management. Call **206-527-6920** or toll-free at **1-888-874-7783**. (Not available in Eastern Washington. Call Customer Service for assistance.)

Audiology/Hear Center locations

Hear Center staff work with your provider to conduct hearing tests and dispense hearing aids. They also clean, adjust, and repair hearing devices and also sell hearing accessories. Visit **ghc.org** for a list of locations and phone numbers. (Not available in Eastern Washington and North Idaho. Call Customer Service for assistance.)

Quit For Life® Program

Quit For Life® is a nationally recognized, telephone-based tobacco cessation program offered through Free & Clear®, originally developed by Group Health Cooperative. To register, call **1-800-462-5327** or go to **freeclear.com/ghc**

ADDITIONAL PLAN INFORMATION

How to file a claim

You can be reimbursed for covered care received out-of-network when these steps are followed:

- You or the provider submit a claim
- You include itemized statements describing the services received, along with the claim form

Send claims for services to:

Basic Health Claims Processing

P. O. Box 34585

Seattle, WA 98124-1585

If you need more claim forms, please ask your employer or call Customer Service.

Loss of eligibility

To continue coverage if you lose eligibility under your medical plan, ask for information about Group Health individual and family plans. They offer a variety of options to fit your budget and health care needs. Call Customer Service for more information.

Motor vehicle accidents

If you are involved in a motor vehicle accident, your automobile insurance will be the first insurer in case of an injury.

On-the-job injuries

If you are injured on the job, tell your employer immediately and complete any necessary internal forms. When you first visit your doctor for this injury, tell the medical receptionist that you have a work-related injury. You will need to complete workers' compensation forms, including a report of the accident. This will help us bill the appropriate insurance carrier.

Other medical insurance

If you or anyone in your family is covered by another health insurance plan, we may need to coordinate your benefits with the other plan to be sure your bills are paid promptly and correctly. Please let us know when you or your family member's coverage changes with the other plan by calling Customer Service.

FIRST RATE CARE— ONLINE AND IN PERSON

"Everything about Group Health Cooperative—our primary caregiver, the facilities, the ability to access records and human beings online, the care that we receive—is first-rate, and we let friends who are considering health care know that."

—Pat Detmer, member



GROUP HEALTH RIGHTS AND RESPONSIBILITIES

As a Group Health Basic Health plan member, you have the right to:

- Be treated with respect and dignity by Group Health staff.
- Be assured of privacy and confidentiality regarding your health and your care.
- Have access to details about your rights and responsibilities as a patient and consumer.
- Be able to access information about Group Health, our practitioners and providers, and how to use our services.
- Receive timely access to quality care and services.
- Have access to information about the qualifications of the professionals caring for you.
- Participate in decisions regarding your health care.
- Give consent to—or refuse—care, and be told the consequences of consent or refusal.
- Have an honest discussion with your practitioner about all your treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your medical condition and ability to understand.
- Join in decisions to receive, or not receive, life-sustaining treatment including care at the end of life.
- Create and update your advance directives and have your wishes honored.
- Choose a personal physician affiliated with your health plan.
- Expect your personal physician to provide, arrange, and/or coordinate your care.
- Change your personal physician for any reason.
- Be educated about your role in reducing medical errors and the safe delivery of care.
- Voice opinions, concerns, positive comments, or complaints.
- Appeal a decision and receive a response within a reasonable amount of time.
- Suggest changes to consumer rights and responsibilities and related policies.
- Receive written information in prevalent non-English language (as defined by the State).
- Receive oral interpretation services free of charge for all non-English languages, and sign or tactile interpretation services for hearing-, sight-, and speech-impairments.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free from all forms of abuse, harassment, or discrimination.
- Be free from discrimination, reprisal, or any other negative action when exercising your rights.
- Request and receive a copy of your medical records, and request amendment or correction to such documents, in accordance with applicable state and federal laws.



GROUP HEALTH RIGHTS AND RESPONSIBILITIES

Your responsibilities as a Group Health Basic Health plan member:

- Provide accurate information, to the extent possible, that Group Health requires to care for you. This includes your health history and your current condition. Group Health also needs your permission to obtain needed medical and personal information. This includes your name, address, phone number, marital status, dependents' status, and names of other insurance companies.
- Use practitioners and providers affiliated with your health plan for health care benefits and services, except where services are authorized or allowed by your health plan, or in the event of emergencies.
- Know and understand your coverage, follow plan procedures, and pay for the cost of care not covered in your contract.
- Understand your health needs and work with your personal physician to develop mutually agreed upon goals about ways to stay healthy or get well when you are sick.
- Understand and follow instructions for treatment, and understand the consequences of following or not following instructions.
- Be active, informed, and involved in your care, and ask questions when you do not understand your care or what you are expected to do.
- Be considerate of other members, your health care team, and Group Health. This includes arriving on time for appointments, and notifying staff if you cannot make it on time or if you need to reschedule.

Voting membership

As a Basic Health member, you can have a voice and a vote in what goes on with your health plan. You will have the power to elect the board that hires the Group Health CEO. You can vote on Group Health bylaw amendments that influence how Group Health Cooperative is run. Every adult member 18 or older has this unique voting privilege. So be sure to sign up and put the power of the Cooperative in your hands. To sign up:

- Go online to **ghc.org**
- Get an application by calling Customer Service at **206-901-4636** or toll-free at **1-888-901-4636**

Access to new treatments

Widespread use of experimental, unproven methods of treatment can often lead to unintended negative health outcomes. Group Health Cooperative has a rigorous process in place to evaluate the effectiveness of experimental treatments. We require that a new test or treatment have an established body of scientific evidence that supports it before encouraging patients and doctors to use it. Such treatments are reviewed by medical, legal, administrative, coverage, and member teams. Doctors are strongly encouraged to discuss all care options with their patients so that patients can make informed choices. For coverage details, please refer to your benefit booklet.

As a Basic Health plan member, you have the right to:

- Get understandable notices or have the materials explained or interpreted
- Receive timely information about your health plan
- Get courteous, prompt answers from your health plan and Basic Health
- Be treated with respect
- Have your privacy protected by Basic Health, your health plan, and its providers
- Get information about all medical services covered by Basic Health
- Choose your health plan and primary care provider from among available health plans and their contracted networks
- Receive proper medical care, consistent with Appendix A of the Basic Health Member Handbook, without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion
- Get all medically necessary covered services and supplies listed in the Basic Health Schedule of Benefits, subject to limits, exclusions, and cost-sharing. Please see your Basic Health Member Handbook.
- Take part in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage
- Get medical care without a long delay
- Refuse treatment and be told of the possible results of refusing, including if your refusal may result in disenrollment from Basic Health.
- Expect your and your child's records and conversations with providers to be kept confidential
- Get a second opinion by another provider in your health plan when you disagree with the initial provider's recommended treatment plan
- Make a complaint about the health plan or providers and receive a timely answer
- File an appeal with your health plan or Basic Health if you are not satisfied with their decision
- Receive a review of a Basic Health appeal decision, if you disagree with it
- Change your primary care provider for a good reason (call your health plan for assistance)

As a Basic Health member, you and/or your enrolled dependents have the responsibility to:

- Understand Basic Health
- Accurately and promptly report changes that may affect your premium or eligibility, such as an address change, or a change in family status or income, and send in the required forms and documentation. (Read Chapters Two and Three of the Basic Health Member Handbook for timelines and instructions.)
- Choose a health plan in your area
- Choose a primary care provider from your health plan before receiving services
- Work with your health plan to help get any third-party payments for medical care
- Tell your health plan about any outside sources of health care coverage or payment, such as insurance coverage for an accident
- Tell your or your child's primary care provider about medical problems, and ask questions about things you do not understand
- Decide whether to receive a treatment, procedure, or service
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral
- Get a referral from the primary care provider before you or your child goes to a specialist
- Pay copayments in full at the time of service
- Pay your Basic Health premiums in full by the due date
- Pay your deductible and coinsurance in full when they are due
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health Plus, the Maternity Benefits Program, your health plan, your primary care provider, or other providers
- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment
- Keep your family members' medical ID cards with the family member at all times, or with you if your children are young
- Notify the health plan or primary care provider within 24 hours, or as soon as is reasonably possible, of any emergency services provided outside the health plan
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs

- Comply with requests for information, including requests for medical records or information about other coverage, by the date requested
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment
- Work with your health plan and providers to learn how to stay healthy

Informed consent

You have the right to give your consent to treatment or care. Be sure to ask your provider about the side effects of your or your child's care. You have the right to know about them, and give your consent before getting care.

Advance directives

Advance directives put your health care choices into writing. They may also name someone to speak for you if you are not able to speak. Washington state law has two kinds of advance directives:

- **Durable Power of Attorney for Health Care:** Names someone to make medical decisions for you if you are not able to make them for yourself.
- **A Directive to Physicians (Living Will):** A document that lets you tell your provider what you do or do not want done if you have a terminal condition or are permanently unconscious.

Under the Patient Self-Determination Act passed by Congress, you have the right to make decisions about your care at the end of life using advance directives. The goal of advance directives is to allow you to make such decisions when you are healthy—not when you are ill and under stress. It also allows you to designate whom you would like to make health care decisions for you if you are unable to do so. An advance directive is a written document. You should discuss it with your provider and family members ahead of time. It can be in the form of a living will (Directive to Physicians) or a Durable Power of Attorney. When you sign a living will or durable power of attorney for health care, two people must witness it. However, you do not need an attorney to prepare it. If you want more information, there is a booklet to help you understand advance directives. For a copy, and the forms that come with it, call **1-800-992-2279**.

Privacy

The Health Care Authority (HCA) and Group Health will not release any personal health information that is provided verbally, electronically, or in writing to anyone but you without your prior written authorization. Exception: Basic Health and DSHS may exchange information about your pregnancy.

If you want to file a grievance

Group Health has a grievance process if you have a complaint. Your complaint will be kept private, except as needed to process your grievance. You can do this if you feel your health care or other services were not good. Or if you feel you were treated rudely. If you file a grievance about a service, provider, or facility, Washington state law limits the information that we may provide regarding the resolution.

Here's how a grievance can be filed:

- It must be done by you or someone you have chosen to speak for you
- It can be done in writing, in person, or by calling
- We will respond to your grievance within 30 days
- You cannot appeal Group Health's response to your grievance
- If you want to file a grievance, please call Customer Service at **1-888-901-4636** or write to:

Membership Communications
P.O. Box 34750
Seattle, WA 98124-9745

If you want to appeal a coverage decision

You have the right to appeal through the Group Health Member Appeals Department. If you choose to appeal, please submit a request within 180 days of the date on this notice.

Who may file an appeal

You, your authorized representative, or your provider may file an appeal. If you want to authorize a representative or your physician to make an appeal, please make this request in writing to the person you are authorizing. Your representative or physician needs to provide Group Health with this documented request to begin a member appeal.

How to file an appeal

Please send your appeal request in writing, in person, or by calling Group Health Customer Service. Please outline why you think the service qualifies for coverage. You may include medical records, physician's letters, or other information you believe may be helpful.



BASIC HEALTH GRIEVANCES AND APPEALS

To request an appeal or request assistance in filing an appeal, please contact one of the offices below:

Western Washington:

**Group Health Cooperative Member Appeals Department
P.O. Box 34593
Seattle, WA 98124-1593
Attn: Appeals Coordinator**

- Or call: **206-901-7359**
- Toll-free: **1-888-901-4636**
- Fax: **206-901-7359**
- WA state TTY/TTD Relay: **711** or **1-800-833-6388**

Eastern Washington:

**Group Health Cooperative Member Appeals Department
P.O. Box 204
Spokane, WA 99224-0204
Attn: Appeals Coordinator**

- Or call: **509-241-7809**
- Toll-free: **1-800-497-2210**
- Fax: **509-458-0368**
- WA state TTY/TTD Relay: **711** or **1-800-833-6388**

Within five working days we will send you a letter notifying you that we have received your appeal request. We will respond within 14 days of receiving a request. If we need more time, we will tell you. Under no circumstances will the review timeframe exceed 30 days without your written permission.

Expedited review

If you or your provider believes that your health could be seriously harmed if action is delayed, you may request an expedited review. Group Health will respond to a request for expedited review within 72 hours if:

- Your provider believes that waiting for 30 days could seriously harm your health; or
- Your provider agrees that your request is medically urgent; or
- You ask for an urgent appeal without support from your provider and we agree that your condition warrants it; or
- Your request does not qualify for expedited review, we will respond within 14 days as outlined above

After the initial appeal

If you are not satisfied with the initial appeal decision or if we fail to respond within the timeframes mentioned above, you may request a second level review by an external Independent Review Organization (IRO) as set forth under section A below. There is no cost to the member for an IRO review. Once a decision is made through an IRO, the decision is final and cannot be appealed through Group Health. You may also choose to pursue review by an appeals committee prior to requesting a review by an independent review organization as described in section B below. **Note:** This is not a required step in the appeals process.

A. After the initial appeal—Independent Review Organization (IRO)

An IRO is not legally affiliated or controlled by Group Health. Once a decision is made through an IRO, the decision is final and cannot be appealed through Group Health. You may ask for an IRO review by calling the Group Health Member Appeals Department toll free at **1-866-458-5479**. There is no cost to the member for an IRO review. Group Health will give the IRO all the information we used in making our decision within three business days of receiving your IRO request. You may be asked to provide additional information or documentation needed for the IRO's decision. A request for a review by an IRO must be made within 180 days after receipt of the initial appeal decision notice, or within 180 days after the date of a Group Health Appeals Committee decision notice. If waiting for the IRO's decision could put your health at risk, you can ask for an expedited (quick) review. In this case the IRO will make a decision within 72 hours and Group Health will notify you of that decision.

B. Request an optional hearing by the Group Health Appeals Committee

The appeals committee hearing is an informal process. The hearing will be conducted within 30 working days of your request and notification of the appeal committee's decision will be mailed to the member within five working days of the hearing. If you choose the appeals committee, you maintain your right to appeal further to an IRO as described above. A request for a hearing by the appeals committee must be made within 30 days after the date of the initial appeal decision notice.

A. Limitations

1. Pre-existing condition waiting period

a. A pre-existing condition is defined as: “Any illness, injury, or condition for which, in the six months immediately preceding a member’s effective date of enrollment in Basic Health:

- (1.) Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
- (2.) Medication was prescribed or recommended for the member; or
- (3.) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.”

b. Waiting period

Basic Health will not provide benefits for services or supplies rendered for any pre-existing condition during the first nine consecutive months following the member’s effective date of coverage. A member will not be required to begin a new nine-consecutive-month waiting period if:

- (1.) Coverage is suspended for not longer than one month during the waiting period, and
- (2.) The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for pre-existing conditions will not be available until the member is actually covered by Basic Health for a total of nine months.

If the member is confined in a health care facility for treatment of a pre-existing condition at the time the member’s nine-month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

c. Exceptions to waiting period

- (1.) The following services are not subject to the waiting period:
 - Maternity care
 - Prescription drugs as defined in your “Pharmacy” benefit
 - Oxygen
 - Routine diabetic care

The 9-month pre-existing condition waiting period is waived for a Basic Health member who is a child up to age 19 or who is diagnosed as a diabetic, or who is identified as a borderline diabetic by their contracted provider. For a diabetic member, the waiting period is waived only for the following covered benefits and services.

- Diabetes education services approved by the health plan for members who meet the following criteria (up to ten hours per calendar year):
 - Diagnosed diabetics
 - Diabetics whose treatment changes from diet control to oral diabetes medication, or from oral diabetes medication to injectable medication



LIMITATIONS AND EXCLUSIONS

- Diabetics with inadequate glycemic control as evidenced by an HbA1c level of 8.5% or more on two consecutive laboratory results three or more months apart during a 12-month period
 - Persons identified by their provider as being at high risk for complications from inadequate glycemic control
 - Yearly eye exam for diabetic retinopathy
 - Outpatient services related specifically to routine care (Examples: Office visits and laboratory services)
 - All other services are subject to the appropriate waiting period as defined in the Basic Health Schedule of Benefits
- (2.) Children up to age 19 are not subject to the nine-month waiting period for pre-existing conditions.

d. Credit toward the waiting period will be given:

- (1.) If Basic Health delays your enrollment (up to a maximum of three months) due to budgetary constraints, and you have been determined eligible.
- (2.) For any continuous period of time during which a member was covered under similar health coverage if:
- That coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three-month period immediately preceding enrollment in Basic Health; and
 - The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage. "Similar coverage" includes Basic Health, all DSHS programs which have the Medicaid scope of benefits, the DSHS program for the medically indigent, Indian Health Services, most coverages offered by health carriers, and most self-insured plans.

2. Major disaster or epidemic

If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of a major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. Coordination of Benefits

The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan, which provides benefits for a Basic Health member except where in conflict with Washington state or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of “Medical Necessity” for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member’s health plan or its contracting providers, except in an emergency.
3. Services received before the member’s effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member’s health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per member per calendar year is covered.
9. Transportation except as specified under “Organ transplants” and “Emergency care.”
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the “Plastic and reconstructive services” benefit.
12. Sex change operations.
13. Investigation of or treatment for infertility or impotence.
14. Reversal of sterilization.
15. Artificial insemination.
16. In-vitro fertilization.
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under “Preventive care.”
18. Hearing aids.

LIMITATIONS AND EXCLUSIONS

19. Orthopedic shoes and routine foot care.
20. Speech and recreation therapy.
21. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" except while the member is hospitalized (including, but not limited to, hospital beds, wheelchairs, and walk aids.)
22. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
23. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
24. Weight loss programs.
25. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
26. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
27. Conditions resulting from acts of war (declared or not).
28. Direct complications arising from excluded services.
29. Replacement of lost or stolen medications.
30. Evaluation and treatment of learning disabilities, including dyslexia.
31. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

Additional services, treatment, or items that are not covered

- Court-ordered services, or any services provided to an enrollee jailed or in legal custody
- Experimental and investigational services
- Sexual dysfunction and treatment
- Medical exams for Social Security Disability
- Orthoptic (eye training) care
- Personal comfort items
- Physical exams for obtaining or continuing employment, insurance, or government licensing.

For details related to any information in this section, please refer to the State of Washington Basic Health Member Handbook.

Rights, responsibilities, and privacy

All information in the Basic Health Member Handbook Rights, Responsibilities, and Privacy chapter, on pages 13–15, applies to Health Coverage Tax Credit (HCTC)–Basic Health members, except as noted below.

- As an HCTC–Basic Health member, you have the right to file an appeal with your health plan or with the federal HCTC program if you are not satisfied with their decision. You will not have an appeals process with Basic Health unless you have paid 100 percent of your premium for the time in question.
- As an HCTC–Basic Health member, you do not have to provide Basic Health with information about your income.
- As an HCTC–Basic Health member, you are not required to pay your premium directly to Basic Health, unless notified. The IRS will send your monthly premium to Basic Health. You will pay 20 percent of that amount directly to the HCTC program.

HCTC–Basic Health grievances and appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. For more information on grievances with your health plan, read “Grievances against your health plan” in the Basic Health Member Handbook.

If you disagree with a decision that you are not eligible for the HCTC program, contact the HCTC Customer Contact Center.

If you have paid 100 percent of your Basic Health premium, and have a complaint about something Basic Health did during the time you paid your own premium, please see page 17 of your Basic Health Member Handbook.

Whenever you call any of these organizations, be sure you note the date of the call, the name of the person you talked to, and whether that person was with the HCTC program, your health plan, or Basic Health.

Health plans and providers

All of Chapter Seven applies to HCTC–Basic Health members.

Covered services

Benefits for HCTC–Basic Health members are the same as for all Basic Health members, with the following exceptions:

- The nine-month waiting period for treatment of pre-existing conditions will be waived if you had at least three months of creditable coverage before enrolling in Basic Health, with no more than a 62-day break in coverage when you applied for HCTC–Basic Health. If you had a break in coverage of 63 days or more at the time of your application to Basic Health, or if you did not have three months of creditable coverage, the nine-month waiting period will apply the same as for all other Basic Health members. For HCTC purposes, creditable coverage includes a group health plan (including COBRA, Temporary Continuation of Coverage [TCC], or state continuation coverage) or health insurance (including individual coverage, college or school insurance, or short-term limited duration insurance).
- HCTC–Basic Health covers maternity benefits without requiring that you apply for the DSHS Maternity Benefits Program. Covered maternity services are listed on pages 20–21 of the Basic Health Member Handbook.

Member costs

Each member enrolled in HCTC–Basic Health will share the cost for his or her health care coverage. See the sections “Member costs,” “If you receive a bill for covered services,” and “If a third party is responsible for your injury or illness” on pages 22–23 of your Basic Health Member Handbook for details.

CONTACT INFORMATION

Emergency Care

Call **911** or your local emergency number.

Urgent Care

Contact your personal physician's office or the Consulting Nurse helpline.

Consulting Nurse Helpline | 1-800-297-6877 or 206-901-2244

24-hour health advice, and more.

Customer Service

For coverage questions, directions to medical centers, to speak to a health plan representative, and more. Representatives are available to assist you Monday through Friday from 8 a.m. to 5:30 p.m.

Seattle area | 206-901-4636

Statewide | 1-888-901-4636

Mail-Order Pharmacy | 1-800-245-7979

Have your prescription refills mailed to your home or work with free delivery.

Notification Line | 1-888-457-9516

If you are admitted to a hospital outside our service area, call the Notification Line within 24 hours, or as soon as possible after admittance.

TTY WA Relay

For members who are hearing- or speech-impaired. Call to access a Group Health facility, physician, or staff member.

Washington | 1-800-833-6388 or 711

Web | ghc.org