

Important Disclosure Information

We appreciate the trust you have placed in us in selecting a health plan offered through Group Health Cooperative or Group Health Options, Inc.

Various state and federal agencies regulate health plan carriers. This document contains or references other sources of information that we are required to provide to you upon your enrollment into a health plan. If you have any questions about this information, please call Customer Service at 1-888-901-4636.

Health Plan Benefit Information

WAC 284-43-820 (1a)

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

Consumer involvement in benefit decisions:

WAC 284-43-820 (1a)

Individual coverage—Individual enrollees can participate in decisions about the kind of health care services offered, through participation as voting members in the Group Health consumer governance process. You can apply to be a voting member by checking the appropriate box on the Individual Coverage Application, or calling Customer Service, or signing up at www.ghc.org.

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

Contact Customer Service for more information about becoming a voting member of Group Health Cooperative.

Information on premiums and enrollee cost-sharing requirements: If you are the individual purchaser of the medical coverage agreement, premium information is available in your application packet and monthly premium bill. If your employer, or a purchasing group such as an association, is the purchaser of the medical coverage agreement, information is available from your employer about any premium cost share that your employer requires for eligibility in the group medical plan. Information about enrollee cost sharing is summarized in your plan's summary of benefits document, available from your health plan carrier or your employer. This information is detailed in your plan's medical coverage agreement (if you are the purchaser of the agreement) or in your certificate of coverage (if your employer is the purchaser of the medical coverage agreement). WAC 284-43-820 (1d)

Information on pre-existing conditions: Your plan may impose a pre-existing condition exclusion. Please refer to your plan's certificate of coverage or medical coverage agreement to confirm if this exclusion applies to you. This means that if you have certain medical conditions before enrolling in the plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, or treatment was recommended or received within the six-month period (three-month period for members whose employer group is larger than 50 employees) prior to the start date of your coverage, or, if you were in a waiting period for coverage, the start date of your waiting period. This exclusion may last up to 9 months (3 months for members whose employer group is larger than 50 employees) from your first day of coverage, or, if you were in

a waiting period, from the first day of your waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. You can reduce the length of the exclusion period by the number of days of your prior “creditable coverage” by providing us with a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways to show that you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to our Customer Service department at 1-888-901-4636.

Point-of-service plan or preferred provider organization (PPO) plan availability: Through some plans offered by Group Health Options, Inc., members may see doctors or go to facilities outside the health plan network for a lower level of coverage than in-network benefits. These types of plans offer more flexibility than coordinated care plans that provide benefits only when using network providers. Members using the out-of-network benefits of their plan usually pay more cost shares and/or have more limitations on coverage. These types of plans are not available through Group Health Cooperative. WAC 284-43-820 (1f)

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

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

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

Quality Program: A description of Group Health Cooperative’s quality program and a report on our progress in meeting our goals is available upon request. NCQA

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

Provider Information

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

How to access specialty care: Specific information for your coverage plan about how to access specialty care and the referral authorization process is available in your health plan’s member guide that is mailed to you upon enrollment. This information is also included in the provider directory. You can access emergency care on your own. Notification to the health plan is required if you are admitted to a noncontracted facility due to an emergency. Generally, nonemergency care must be authorized in advance by a primary care doctor and your health plan, including follow-up care subsequent to emergency care. Some covered services are available without a referral from your provider; check your benefit booklet or call Customer Service for more information. Health care obtained without a referral is reviewed retrospectively to ensure that medically appropriate care and services were delivered. If you are on a PPO plan, referrals and pre-authorization for covered services are not required, except for transplant services. Case management services are provided by your health plan to members with complex medical needs. WAC 284-43-820 (2b, 2c)

Provider compensation: Your health plan's goal is to fairly compensate medical care providers for care that meets high professional standards. Providers are strongly encouraged to discuss all care options with their patients. There are no incentives to withhold such information nor are there incentives to withhold medically necessary services. A variety of provider compensation methods are used by the health plan carriers who have contracts with or employ the providers who render medical services to patients. Some providers are paid a salary for their services, some are paid a capitation fee (an amount that is paid monthly to a provider to provide a certain set of services for members), some are paid from a fee schedule (a predetermined amount that the health plan will pay for certain services), and some providers are paid at a discounted amount from their billed charges. At times, additional payments (a bonus or an incentive payment) may be paid to an individual provider or provider group based on achieving specific customer satisfaction scores on standardized surveys or other specified performance measures, such as member access. WAC 284-43-820 (2d, 2e)

Women's Health and Cancer Rights

If you are receiving benefits for a covered mastectomy and elect breast reconstruction in connection with the mastectomy, you will also receive coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with you and your attending physician and will be subject to the same annual deductible, coinsurance and copayment provisions otherwise applicable under the plan.

Mental Health Coverage Information

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

Pharmacy Benefit Information

WAC 284-43-820 1(b), WAC 284-43-815, WAC 284-43-820 1(b)

The following information applies only to health plans that have pharmacy benefits. This information is detailed in your plan's medical coverage agreement (if you are the purchaser of the agreement) or in your certificate of coverage (if your employer is the purchaser of the medical coverage agreement).

Definitions of pharmacy related terms:

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

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

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

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

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

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

Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs? Your health plan carrier, working with pharmacists and care providers, has developed a drug formulary to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. A drug formulary is a list of preferred pharmaceutical products. Nonformulary drugs are not covered unless approved by your health plan as medically necessary or may be subject to a higher cost than formulary drugs, depending on the benefits of your specific plan.

Generic drugs will be dispensed unless a suitable generic is not available. If you elect to purchase a brand-name drug instead of the generic equivalent (if available), or if you elect to purchase a different brand-name or generic drug than that prescribed by your provider, you will be responsible for payment of the additional cost above the generic drug charge in addition to your plan pharmacy cost share. Vitamins, including legend (prescription) vitamins, and medicines and injections for anticipated illness while traveling, are generally excluded from all plans. Exclusion of other categories of drugs will depend on your specific coverage plan. For example, drugs for treatment of sexual dysfunction are not covered unless your medical plan covers treatment of sexual dysfunction. Contact Customer Service to request a copy of the drug formulary for your specific plan.

When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using? Changes to the plan's drug formulary are implemented on an ongoing basis, based on an established evaluation process. The evaluation process includes review of scientific studies. The scientific studies reviewed must have been published in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts.

Your care provider or pharmacist will notify you when you refill a prescription if the prescribed drug is no longer included in the plan's drug formulary. When a drug has been removed from the plan formulary, it will not be covered unless your plan, at its discretion, elects to cover the drug for a limited time or the drug may be subject to a higher cost depending on the benefits of your specific plan.

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

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

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

How much do I have to pay to get a prescription filled? The amount of your out-of-pocket expense (cost share) depends on the specific pharmacy coverage you or your employer has purchased and on the medication prescribed. In general, the prescription copay or coinsurance amount applies for up to a 30-day supply of each covered prescription. If the actual charge for the drug is less than your cost share, you will pay only the actual charge for the drug. If your provider prescribes a noncovered medication, you will pay the actual charge for the drug.

If you are on a point-of-service or PPO plan, you will pay the cost share specified for drugs provided under the managed-care or preferred-provider option (in-network pharmacies, prescribed by plan providers) or the cost share amount specified for drugs provided by community providers (nonparticipating pharmacies and providers). If you have pharmacy coverage through a group that has a tiered cost share benefit, you will pay a lower cost share for generic drugs, and higher cost share for brand-name drugs. In addition, nonformulary drugs may be subject to a higher cost share.

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

If you are covered under a point-of-service or PPO plan, using the in-network providers and pharmacies will provide the highest coverage level and the least amount of out-of-pocket cost to you. If you use your out-of-network benefits, you will pay a higher cost share, and you need to have your prescriptions filled through a large network of participating pharmacies through the MedCare pharmacy network. This network includes most major retail pharmacies. If you use a nonparticipating pharmacy outside the MedCare network, your prescription will not be covered under your plan's out-of-network benefit. At any pharmacy, if you elect to purchase a noncovered drug, you will pay the actual charge for the drug, not the plan's copay or coinsurance. Call Customer Service to find out which pharmacies are in the MedCare network in your area, or if you anticipate needing to fill a prescription when you are traveling.

How many days supply of most medications can I get without paying another copay or other repeating charge? Your plan contract allows up to a 30-day supply of prescription or refill per copay or cost share amount. If you get a three-month supply of a maintenance drug, you will be charged three pharmacy copays or cost share amounts.

What other pharmacy services does my health plan cover? A mail-order prescription refill service is available. Contact Customer Service for your plan's specific mail-order pharmacy benefits. At Group Health Cooperative, the Pharmacy Department is involved in the development of clinical roadmaps and clinical guidelines. The Pharmacy Department participates in, or plays a role in, medication use and disease management programs for smoking cessation and for such conditions as diabetes, HIV/AIDS, asthma, depression, migraine headache, GERD (Gastroesophageal Reflux Disease), and heart problems.

Health Information Practices

WAC 284-43-820 (1c)

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

Notice of Privacy Practices

of Group Health Cooperative and related organizations

Uses and disclosures of your personal health information

Effective Date: April 14, 2003

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

This Notice covers the privacy practices of the following organizations:

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

Group Health's responsibilities

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Group Health must take steps to protect the privacy of your "protected health information" (PHI.) PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Under federal law, we are required to:

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

Uses and disclosures of your protected health information by Group Health that do NOT require Group Health uses and discloses PHI in a number of ways connected to your treatment, payment for your care, and our health care operations. Some examples of how we may use or disclose your PHI without your authorization are listed below.

We may use or disclose your protected health information without your authorization as follows in relation to your health care and treatment:

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

We may use or disclose your protected health information without your authorization as follows in relation to payment:

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

We may use or disclose your protected health information without your authorization as follows in relation to health care operations:

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your PHI to review and improve the care you receive, to provide training, and to help decide what rates to charge.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your PHI with other organizations for this purpose, they must agree to protect your privacy.)

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

- **Required by law**—When we are required to do so by state and federal law, including workers' compensation laws.
- **Public health and safety**—To an authorized public health authority or individual to:
 - Protect public health and safety.
 - Prevent or control disease, injury, or disability.
 - Report vital statistics such as births or deaths.
 - Investigate or track problems with prescription drugs and medical devices by the Food and Drug Administration.
- **Abuse or neglect**—To government entities authorized to receive reports regarding abuse, neglect, or domestic violence.
- **Oversight agencies**—To health oversight agencies for certain activities such as audits, examinations, investigations, inspections, and licensures.
- **Legal proceedings**—In the course of any legal proceeding in response to an order of a court or administrative agency and, in certain cases, in response to a subpoena, discovery request, or other lawful process.
- **Law enforcement**—To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- **Military activity and national security**—To the military and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the president of the United States.

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

- **Family and friends**—To a member of your family, a relative, a close friend — or any other person you identify who is directly involved in your health care — when you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest. For example, we may disclose PHI to a friend who brings you into an emergency room.
- **Facility directory information**—Unless you object upon admission, we may use and disclose your name, the location at which you are receiving care, your general condition, and your religious affiliation in our facility directory. All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy will be told your religious affiliation if they ask. This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- **Appointment reminders**—To you, to remind you in writing or by phone/voicemail that you have a health care appointment with us. These reminders may be made by postcard, phone, or voicemail unless you specifically ask us to communicate with you through a different method as described later in this Notice.
- **Treatment alternatives and plan description**—To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you, or to describe our health plan and providers to you.

- **Employer group health plans**—If you are enrolled in Group Health through your work and your employer has adopted certain privacy procedures, we may communicate with your employer for certain administrative activities. (Please ask your employer for more details.)
- **Fundraising**—To contact you for Group Health or Group Health Community Foundation fundraising purposes. (We would only release information such as your name, address, phone number, and dates that you received treatment or service from us.) You will be given the opportunity to instruct us to not contact you for this purpose.
- **Research**—For Group Health or another organization’s research purposes provided that certain steps are taken to protect your privacy. Note: Generally in these cases a research review board will review the research project to ensure adequate privacy protections before Group Health uses or discloses your PHI.
- **De-identify information**—To “de-identify” information by removing information from your PHI that could be used to identify you.
- **Coroners, funeral directors, and organ donation**—To coroners, funeral directors, and organ donation organizations as authorized by law.
- **Disaster relief**—To an authorized public or private entity for disaster relief purposes. For example, we might disclose your PHI to help notify family members of your location or general condition.
- **Threat to health or safety**—To avoid a serious threat to the health or safety of yourself and others.
- **Correctional facilities**—If you are an inmate in a correctional facility we may disclose your PHI to the correctional facility for certain purposes, such as providing health care to you or protecting your health and safety or that of others.

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

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

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

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

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

Your rights regarding your protected health information

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

You have the right to:

- **Request restrictions** by asking that we limit the way we use or disclose your PHI for treatment, payment, or health care operations. You may also ask that we limit the information we give to someone who is involved in your care, such as a family member or friend. Please note that we are not required to agree to your request. If we do agree, we will honor your limits unless it is an emergency situation.
- **Ask that we communicate with you** by another means. For example, if you want us to communicate with you at a different address we can usually accommodate that request. We may ask that you make your request to us in writing. We will agree to reasonable requests.
- **Request a copy of your PHI.** We may ask you to make this request in writing and we may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.

- **Ask us to amend PHI** about you that we use to make decisions about you. Your request for an amendment must be in writing and provide the reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included with your PHI.
- **Seek an accounting of certain disclosures** by asking us for a list of the times we have disclosed your PHI. Your request must be in writing and give us the specific information we need in order to respond to your request. You may request disclosures made up to six years before your request. You may receive one list per year at no charge. If you request another list during the same year, we may charge you a reasonable fee. These lists will not include disclosures to other organizations that might pay for your care provided by Group Health.
- **Request a paper copy of this Notice.**

Changes to privacy practices

Group Health may change the terms of this Notice at any time. The revised Notice would apply to all PHI that we maintain. If we change any of the practices described in this Notice, we will post the revised Notice on enrollee-accessible web sites and at Group Health clinics.

Questions and complaints

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

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

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

