

Important Disclosure Information

We appreciate the trust you have placed in us by 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

RCW 48-43-510 (1a)

Upon request, we will provide you with a listing of covered benefits and how members 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:

RCW 48-43-510 (1a)

INDIVIDUAL COVERAGE—Individual members 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 members 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 MEMBER COST-SHARING REQUIREMENTS: If you are the individual purchaser of the medical coverage agreement, premium information is available in your application packet and on the 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 member 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). RCW 48-43-510 (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 a certain medical condition 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 members under the age of 19 (except for the grandfathered individual and family plan coverage). The pre-existing conditions exclusion does not apply to some services (please refer to your plan's certificate of coverage or medical coverage agreement). 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 (COCC) 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 Pre-existing Condition Exclusion Unit at 1-888-459-2467. Please send Certificate of Creditable Coverage (COCC) copies to the following address: Group Health, Pre-existing Condition Exclusion Unit, PO Box 210, Spokane, WA 99210. You may also e-mail a scanned version of the COCC to pceunit@ghc.org or FAX a copy to 206-877-0730.

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. RCW 48-43-510 (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. RCW 48-43-510 (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. RCW 48-43-510 (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. RCW 48-43-510 (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. RCW 48-43-510 (1e, 2g)

CLINICAL PRACTICE GUIDELINES: Group Health develops clinical practice guidelines, through scientifically proven, evidence-based medicine, not fads or trends. For more information or if you would like a copy of a clinical guideline, please call Customer Service at 1-888-901-4636.

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 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. RCW 48-43-510 (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. RCW 48-43-510 (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. RCW 48-43-510 (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

RCW 48-43-510 (1a), RCW 48-43-510 (1b), WAC 284-43-815

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. RCW 48-43-510 (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 other 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 member 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. All of our 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 conditions such as diabetes, HIV/AIDS, asthma, depression, migraine headache, GERD (Gastroesophageal Reflux Disease), and heart problems.

HEALTH INFORMATION PRACTICES

RCW 48-43-510 (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

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 is effective April 1, 2010.

At Group Health Cooperative, safeguarding your privacy and the confidentiality of your personal information has always been a priority.

Our internal policies and procedures are designed to control and protect the confidentiality and security of your personal information whether in written, oral, or electronic format. We train our employees on these policies and procedures. Employees who violate our confidentiality and security policies are subject to disciplinary action.

This notice is based on state and federal law, as well as our own code of ethics. We are required by law to protect the privacy of your personal information and provide you with this notice, which explains our responsibilities and privacy practices regarding your personal information. We are also required to abide by the terms of this notice.

In this notice, the term "personal information" refers to any medical or financial information that can reasonably be used to identify you and relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care. Personal information may include your name, Social Security number, address, telephone number, employment, medical history, health records, claims information, or credit card number.

This notice applies to all patients receiving care in Group Health Cooperative owned and operated facilities as well as members covered under Group Health Cooperative and Group Health Options, Inc. plans. This notice applies to patients being cared for in Group Health Cooperative facilities by Group Health Permanente doctors and clinicians as well as other contracted providers with which we have Organized Health Care Arrangements (OHCA). Group Health Cooperative and our OHCA partners use and share our patients' personal information to provide health care treatment, receive payment for health care services provided, or for health care operations. Health care operations are business activities that support the delivery of health care. In this notice the terms "we," "us," "our", and "Group Health" describe and apply to all of these entities.

ABOUT GROUP HEALTH

Group Health Cooperative and Group Health Options, Inc. offer health care coverage to members through individual and group plans. Group Health Cooperative also directly delivers care in our owned and operated medical facilities. Depending on your relationship with Group Health, we may collect, use, and share your information in slightly different ways.

When you apply for health coverage with Group Health, we may receive your personal information directly from you or from third parties which may include agents, producers, a trust, or your employer. We may share your personal information with the health plan administrator through which you receive your health benefits, to permit them to manage the business functions of the health plan. For example, we may share enrollment and eligibility information with plan administrators. We may also share information that does not identify specific members with a plan administrator to obtain premium bids or to modify or terminate a health plan.

If you are enrolled in a self funded plan through your employer, Group Health Cooperative and Group Health Options, Inc. may act as an "administrative services organization" for your self funded plan and may receive and share information with the plan administrator, usually your employer, for certain administrative activities. For example, we may share claims information for health care services you have received. The plan administrator must confirm that it will protect your personal information in accordance with law. Please ask your employer for more details.

If you are a patient at a Group Health Cooperative owned and operated medical facility, we keep a record of health care services you receive from us as well as medical records sent to us from other providers. We will not share your information with others unless you direct us to or the law authorizes or requires us to. For more information, see the section in this notice, "How we may use and share your personal information".

YOUR RIGHTS

You have rights regarding personal information that we maintain about you. If you do not receive treatment in a Group Health Cooperative medical facility, some of these statements may not apply to you. You may get more information about exercising any of these rights by calling the Privacy Office at 206-448-2422.

REQUEST RESTRICTIONS—You may request that we limit the way we use or share your personal information outside of Group Health. You may also ask that we limit the information we give to friends and family members involved in your care.

CONFIDENTIAL COMMUNICATION—You may ask that we contact you at a different address or phone number. We will usually be able to accommodate your request. Please make your request to us in writing.

INSPECT AND COPY—You may review and request a copy of information in your medical record, maintained by Group Health Cooperative. We may ask you to make this request in writing. We may charge a reasonable fee for the cost of producing and mailing the copies. In certain situations we may deny your request and tell you why we are denying it. You have the right to ask for a review of our denial.

AMENDMENTS—You may ask us to correct or amend information in your medical record. Your request for a change to your medical record must be in writing and give a reason for your request. We may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with your medical record.

ACCOUNTING OF DISCLOSURES—You may seek an accounting of certain disclosures by asking us for a list of the times we have shared your personal medical information. Your request must be in writing and give us the specific information we need in order to respond to your request.

RECEIVE AN ADDITIONAL COPY OF THIS NOTICE—You may request a copy or ask general questions about this notice by calling Group Health Customer Service at 206-901-4636 or toll free at 1-888-901-4636. You may also view this notice on our Web site at www.ghc.org

How we may use and share your personal information

Group Health uses and shares your personal information 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 share your personal information without your authorization are described below. If you do not receive your health care from Group Health Cooperative, some of the following examples may not apply to you.

Treatment

If you are a patient in a Group Health Cooperative medical facility, we may use or share your personal information to provide you medical care. For example, our physicians, nurses, pharmacists, and lab technicians may share your health information to provide you health care services. In addition, we may share your health information with health care providers or suppliers outside of Group Health for consultation, referral, or coordination of your care.

Payment

If you are a Group Health Cooperative or Group Health Options, Inc. member, we may receive your personal information from health care providers who treat you so we can pay them in accordance with your health benefit plan. We may use or share your personal information for payment of the care you receive. Payment purposes could also include determining benefit eligibility and coordinating benefits with other health plans, reviewing services for medical necessity, paying a claim, performing utilization review, obtaining premiums, subrogating a claim, and collection activities.

Health care operations

We may use and share your personal information to carry out health care operations. For example, we may use your personal information to review and improve the care you receive, to provide care management, for health plan underwriting, to administer and review a health plan, to conduct medical reviews, and to provide customer service. It may also include determining coverage policies, business planning, arranging for legal and auditing services, and obtaining accreditations and licenses. Please note that Group Health is not allowed to use or share your genetic information for underwriting purposes, to adjust premiums, or make enrollment/eligibility determinations based on your predisposition to a genetic condition. Group Health is also prohibited from requesting, requiring or purchasing genetic information about an individual prior to enrollment. Incidental collection of genetic information does not violate the law.

We may also contract with individuals or entities known as business associates, to work on our behalf which may require us to use and share your personal information. Our business associates must agree in writing to safeguard the confidentiality of your personal information.

Certain state and federal laws may require us to share your personal information. For example, we may be obligated to share your information:

- With an authorized public health authority or their agent to protect public health and safety; prevent or control certain diseases, injuries, or conditions; to report vital events such as births or deaths; and to investigate or track problems with prescription drugs and medical devices requested by the U.S. Food and Drug Administration (FDA). We may also participate in registries required by law, such as the cancer registry or the trauma registry.
- With the workers' compensation program which provides benefits to you if you have a work-related injury or illness.
- With government benefit programs, like Medicare and Medicaid, in order to review your eligibility and enrollment in these programs.
- With government entities authorized to receive reports regarding child or vulnerable adult abuse or neglect.
- With health oversight agencies. As health plans and health care providers, we must agree to oversight reviews by federal and state agencies. These agencies may, by law conduct audits, perform inspections and investigations, license health care providers, health plans and health care facilities, and enforce federal and state regulations.
- In response to a court order and in certain cases, in response to a subpoena, discovery request, or other lawful process.
- With law enforcement officials in limited circumstances. For example, disclosures may be made to report a crime on Group Health property.
- With armed forces personnel for military activities and to authorized federal officials for national security activities and intelligence purposes.
- With funeral directors, and organ donation organizations as authorized by law to assist with their responsibilities.
- To county coroners for the investigation of deaths as authorized by law.
- To a correctional facility if you are an inmate. We may share your personal information as allowed by law for your health and the health and safety of others.
- We may also use and share your health information to avert a threat to the health and safety of a person or the public.

We may also use or share your personal medical information without your authorization in the following circumstances:

FAMILY, DOMESTIC PARTNER, OR FRIEND—To a family member, domestic partner, friend, or a person you identify when you are present and agree, or when you are not present or are incapacitated and in our professional judgment it is in your best interest to disclose information about your care.

FACILITY DIRECTORY INFORMATION—If you are a patient, in some cases we may use and share your name, the location you are receiving care, your general condition, and your religious affiliation in our facility directory. You will be given the opportunity to decline.

APPOINTMENT REMINDERS—If you are a patient, to remind you by mail or phone that you have a health care appointment with us.

PLAN DESCRIPTION—To communicate with you about our networks, health plans, and providers.

PREVENTIVE HEALTH SERVICES AND TREATMENT ALTERNATIVES —To remind you about preventive health services or to let you know about treatment alternatives, providers, settings of care, or health and wellness products or services that are available for you as a member of Group Health.

FUNDRAISING—We may contact you to raise funds for the Group Health Foundation, a nonprofit charitable organization supporting Group Health and the community. We only use 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 direct us not to contact you for this purpose.

RESEARCH—For medical research conducted by the Group Health Research Institute or other research teams, provided that certain steps are taken to protect your privacy. Generally an institutional research review board evaluates each research project to ensure researchers follow processes that will protect your privacy before your personal medical information is shared with researchers or used in a research study.

Other uses of your medical information

Except in the situations described above, we will use and share your personal information only with your written permission or authorization. In some situations, federal and state laws provide special protections for specific kinds of personal medical information and require authorization from you before we can share that specially protected medical information. For example, information about treatment for alcohol or drug abuse, sexually transmitted disease, and mental health is specially protected. In these situations and for any other purpose, we will contact you for the necessary authorization. If you sign an authorization to release your health care information, you may withdraw it at any time by letting us know in writing.

Questions and complaints

If you have questions about this notice or want to file a complaint about our privacy practices, including our process for breach notification, write to Group Health Privacy Officer, Group Health Cooperative, 320 Westlake Ave N, 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 may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint about our privacy practices with us or with the Department of Health and Human Services.

Changes to privacy practices

We may change the terms of this notice at any time. If we change any of the privacy practices described in this notice, we will post the revised notice on our Web site, at www.ghc.org and in Group Health medical facilities. We may also give you additional information about our privacy practices in other notices we provide.

