GROUP HEALTH COOPERATIVE
BENEFITS & COVERAGE
P.O. BOX 34589
SEATTLE WA 98124-1589

INDIVIDUAL & FAMILY
VISITSPLUS
MEDICAL COVERAGE AGREEMENT

VisitsPlus Silver HD - 17

Nonacceptance of Agreement.
If for any reason the Contract Holder is not satisfied with this Agreement, it may be terminated by its return to Group Health or the producer within 10 days of delivery. It is assumed that delivery will have occurred within 3 days of the date mailed by Group Health. In the event that the Agreement is returned within 10 days, Group Health shall promptly refund all premium received in connection with the issuance and the Agreement shall be void from the beginning. If Group Health does not refund payments within 30 days of its timely receipt of the returned Agreement, it must pay a penalty of 10% of such premium. The refund will be reduced based on payment made for received services.

Group Health Cooperative
Individual & Family Plan
VisitsPlus HD Silver - 17

Group Health Cooperative ("Group Health") is a nonprofit health maintenance organization, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepayment basis. This medical coverage agreement ("Agreement") sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting party; requirements for enrollment and eligibility; and benefits to which those enrolled under this Agreement are entitled.

This Agreement is made between Group Health Cooperative and the individual designated herein as the "Contract Holder". The Agreement between Group Health and the Contract Holder consists of the following:

- Signed Individual and Family application
- Medical Coverage Agreement
- Premium schedule

This Agreement is in force beginning [Eff Date].

Important Notice Under Federal Health Care Reform

Group Health recommends each Member choose a Network Personal Physician. This decision is important since the designated Network Personal Physician provides or arranges for most of the Member's health care. The Member has the right to designate any Network Personal Physician who participates in Group Health's Core Network and who is available to accept the Member or the Member's family members. For information on how to select a Network Personal Physician, and for a list of the participating Network Personal Physicians, please call the Group Health Customer Service Center at (206) 901-6924 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

For children, the Member may designate a pediatrician as the primary care provider.

The Member does not need Preauthorization from Group Health or from any other person (including a Network Personal Physician) to access obstetrical or gynecological care from a health care professional in the Group Health network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Preauthorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Group Health Customer Service Center at (206) 901-6924 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

Women's health and cancer rights

If the Member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the Member 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.
- Prostheses.
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the Member and the attending physician and will be subject to the same Cost Shares otherwise applicable under the Benefits Booklet.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Carriers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For More Information

Group Health will provide the information regarding the types of plans offered by Group Health to members on request. Please call the Group Health Customer Service Center at (206) 901-6924 in the Seattle area, or toll-free in Washington, 1-800-290-8900.

Standard Provisions

1. Group Health agrees to provide benefits as set forth in the medical coverage Agreement to the Contract Holder.

2. **Monthly Premium Payments.**
   Monthly premium payments must be made to Group Health in compliance with Group Health's terms and guidelines.

3. **Identification Cards.**
   Group Health will furnish cards, for identification purposes only, to all Members enrolled under this Agreement.

4. **Administration of Agreement.**
   Group Health may adopt reasonable policies and procedures to help in the administration of this Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determinations.

5. **Modification of Agreement.**
   This Agreement, including premium, may be modified by Group Health upon 30 days written notice mailed to each Contract Holder's address, as it appears in Group Health's records. Failure to receive such notice shall not affect the modification or effective date thereof. Call the Group Health Customer Service Center at (206) 901-6924 in the Seattle area, or toll-free in Washington, 1-800-290-8900 to provide a change of address.

   No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

6. **Notices.**
   The Contract Holder shall notify either the Washington Health Benefit Exchange in compliance with their guidelines or Group Health in writing of any changes in residence within 30 days of such change. Notices provided for in this Agreement shall be mailed to Group Health at its principal address and to the Contract Holder's address as it appears in Group Health's records.

7. **Compliance With Law.**
   Group Health and the Contract Holder shall comply with all applicable state and federal laws and regulations in performance of this Agreement. This Agreement is entered into and governed by the laws of Washington State, except as otherwise pre-empted by federal laws.

8. **Governmental Approval.**
   If Group Health has not received any necessary government approval by the date when notice is required under this Agreement, Group Health will notify the Contract Holder of any changes once governmental approval has been received. Group Health may amend this Agreement by giving notice to the Contract Holder upon receipt of government approved rates, benefits, limitations, exclusions or other provisions, in which case such rates, benefits, limitations, exclusions or provisions will go into effect as required by the governmental agency. All amendments are deemed accepted by the Contract Holder unless the Contract Holder gives Group Health written notice of non-acceptance within 10 days after receipt of amendment, in which event this Agreement and all rights to services and other benefits terminate on the said date.

9. **Confidentiality.**
   Group Health is required by federal and state law to maintain the privacy of Member personal and health information. Group Health is required to provide notice of how Group Health may use and disclose personal and health information held by Group Health. The Notice of Privacy Practices is distributed to Members and is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.

10. **Nondiscrimination.**

Group Health does not discriminate on the basis of physical or mental disabilities in its employment practices and services. Group Health will not refuse to enroll or terminate a Member's coverage on the basis of age, sex, race, religion, occupation or health status.

11. Termination of Entire Agreement.

This is a guaranteed renewable Agreement and cannot be terminated except as provided in compliance with the Group Health or Washington Health Benefit Exchange terms and guidelines.

12. Withdrawal or Cessation of Services.

a. Group Health may determine to withdraw from a Service Area or from a segment of its Service Area after Group Health has demonstrated to the Washington State Office of the Insurance Commissioner that Group Health's clinical, financial or administrative capacity to service the covered Members would be exceeded.

b. Group Health may determine to cease to offer the plan and replace the plan with another plan offered to all covered Members within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. Group Health may also allow unrestricted conversion to a fully comparable Group Health product.

Group Health will provide written notice to each covered Member of the discontinuation or non-renewal of the plan at least 90 days prior to discontinuation.

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I. Introduction

This Agreement is a statement of the terms of enrollment, payment and coverage under which the Contract Holder may secure health benefits. Group Health, through the Board of Trustees elected by Group Health Members, endeavors to provide a wide range of medical and hospital care through its staff and facilities.

The provisions of the Agreement must be considered together to fully understand the benefits available under the Agreement. Words with special meaning are capitalized and are defined in Section XII. If the Member is eligible for Medicare, the Member should read Section IV. Drugs – Outpatient Prescription as it may affect their prescription drug coverage.

Contact Group Health Customer Service at 206-901-6924 or toll-free 1-800-290-8900 for benefits questions.

II. How Covered Services Work

A. Accessing Care.

1. **Members are entitled to Covered Services** only at Group Health's Core Network (Network) Facilities and from Group Health's Core Network (Network) Providers, except for Emergency services and care pursuant to a Preauthorization.

   A listing of Network Personal Physicians, specialists, women's health care providers and Group Health-designated Specialists is available by contacting Customer Service or accessing the Group Health website at www.ghc.org. See the Definitions Section XII. for more information on these providers.

2. **Primary Care Provider Services.**
   Group Health recommends that Members select a Network Personal Physician when enrolling. One Network Personal Physician may be selected for an entire family, or a different Network Personal Physician may be selected for each family member. For information on how to select or change Network Personal Physicians, and for a list of participating Network Personal Physicians, call the Group Health Customer Service Center at (206) 901-6924 in the Seattle area, or toll-free in Washington at 1-800-290-8900 or by accessing the Group Health website at www.ghc.org. The change will be made within 24 hours of the receipt of the request if the selected physician's caseload permits. If a Network Personal Physician accepting new Members is not available in your area, contact the Group Health Customer Service Center, who will ensure you have access to a Network Personal Physician by contacting a physician's office to request they accept new Members.

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

3. **Specialty Care Provider Services.**
   Unless otherwise indicated in Section II. or Section IV., Preauthorization is required for specialty care and specialists that are not Group Health-designated Specialists and are not providing care at facilities owned and operated by Group Health.

   Specialty Care Provider Copayment.
   The following providers are subject to the specialty Copayment level: allergy and immunology, anesthesiology, audiology, cardiology (pediatric and cardiovascular disease), critical care medicine, dentistry, dermatology, endocrinology, enterostomal therapy, gastroenterology, genetics, hepatology, infectious disease, massage therapy, neonatal-perinatal medicine, nephrology, neurology, nutrition, hematology/oncology, occupational medicine, occupational therapy, ophthalmology, orthopedics, ENT/otolaryngology, pathology, physiatry (physical medicine), physical therapy, podiatry, pulmonary medicine/disease, radiology (nuclear medicine, radiation therapy), respiratory therapy, rheumatology, speech therapy, sports medicine, general surgery and urology.

Group Health-designated Specialist.
Members may make an appointment with Group Health-designated Specialists at facilities owned and operated by Group Health without Preauthorization. To access a Group Health-designated Specialist, consult your Network Personal Physician, contact Customer Service for a list of Group Health designated specialists, or view the Provider Directory located at www.ghc.org. The following specialty care areas are available from Group Health-designated Specialists: allergy, audiology, cardiology, chemical dependency, chiropractic, dermatology, gastroenterology, general surgery, hospice, manipulative therapy, mental health, nephrology, neurology, obstetrics and gynecology, occupational medicine, oncology/hematology, ophthalmology, optometry, orthopedics, otolaryngology (ear, nose and throat), physical therapy, smoking cessation, speech/language and learning services and urology.

4. **Hospital Services.**
Non-Emergency inpatient hospital services require Preauthorization. Refer to Section IV. for more information about hospital services.

5. **Emergency Services.**
Emergency services at a Network Facility or non-Network Facility are covered. Members must notify Group Health by way of the Group Health Hospital notification line (1-888-457-9516 as noted on your Member identification card) within 24 hours of any admission, or as soon thereafter as medically possible. Coverage for Emergency services at a non-Network Facility is limited to the Allowed Amount. Refer to Section IV. for more information about Emergency services.

6. **Urgent Care.**
Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Outside the Group Health Service Area, urgent care is covered at any medical facility. Refer to Section IV. for more information about urgent care.

7. **Women's Health Care Direct Access Providers.**
Female Members may see a general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advance registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without Preauthorization, for Medically Necessary maternity care, covered reproductive health services, preventive services (well care) and general examinations, gynecological care and follow-up visits for the above services. Women's health care services are covered as if the Member's Network Personal Physician had been consulted, subject to any applicable Cost Shares. If the Member's women's health care provider diagnoses a condition that requires other specialists or hospitalization, the Member or her chosen provider must obtain Preauthorization in accordance with applicable Group Health requirements.

8. **Process for Medical Necessity Determination.**
Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

First Level Review:

First level reviews are performed or overseen by appropriate clinical staff using Group Health approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the Member's medical record, and consultation with the attending/referring physician and multidisciplinary health care team. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The Member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the requesting physician when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the

requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second Level (Practitioner) Review:

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the requesting physician when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

B. Preauthorization.
Covered Services may require Preauthorization. Refer to Section IV. for more information. Group Health recommends that the provider requests Preauthorization. Members may also contact Customer Service. Preauthorization requests are reviewed and approved based on Medical Necessity, eligibility and benefits.

C. Recommended Treatment.
Group Health's medical director will determine the necessity, nature and extent of treatment to be covered in each individual case and the judgment, will be made in good faith. Members have the right to appeal coverage decisions (see Section VIII.). Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended services to the extent permitted by law. Members who obtain care not recommended by Group Health's medical director do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care.

D. Second Opinions.
The Member may access a second opinion from a Network Provider regarding a medical diagnosis or treatment plan. The Member may request Preauthorization or may visit a Group Health-designated Specialist for a second opinion. When requested or indicated, second opinions are provided by Network Providers and are covered with Preauthorization, or when obtained from a Group Health-designated Specialist. Coverage is determined by the Member's Agreement; therefore, coverage for the second opinion does not imply that the services or treatments recommended will be covered. Preauthorization for a second opinion does not imply that Group Health will authorize the Member to return to the physician providing the second opinion for any additional treatment. Services, drugs and devices prescribed or recommended as a result of the consultation are not covered unless included as covered under the Agreement.

E. Unusual Circumstances.
In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, Group Health will not be liable for administering coverage beyond the limitations of available personnel and facilities.

In the event of unusual circumstances such as those described above, Group Health will make a good faith effort to arrange for Covered Services through available Network Facilities and personnel. Group Health shall have no other liability or obligation if Covered Services are delayed or unavailable due to unusual circumstances.

F. Utilization Management.
All benefits are limited to Covered Services that are Medically Necessary and set forth in the Agreement. Group Health may review a Member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, Group Health may deny coverage if, in its determination, such services are not Medically Necessary. Such determination shall be based on established clinical criteria.

Group Health will not deny coverage retroactively for services with Preauthorization and which have already been provided to the Member except in the case of an intentional misrepresentation of a material fact by the patient, Member, or provider of services, or if coverage under this Agreement was obtained based on inaccurate, false, or misleading information provided on the enrollment application; or for nonpayment of premiums.

III. Financial Responsibilities

A. Premium.

The Contract Holder is liable for payment of premium.

B. Financial Responsibilities for Covered Services.

The Contract Holder is liable for payment of the following Cost Shares for Covered Services provided to the Contract Holder and his/her Dependents. Payment of an amount billed must be received within 30 days of the billing date. Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.

1. Annual Deductible.

Covered Services may be subject to an annual Deductible. Charges subject to the annual Deductible shall be borne by the Contract Holder during each year until the annual Deductible is met. Covered Services must be received from a Network Provider at a Network Facility, unless the Member has received Preauthorization or has received Emergency services.

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

2. Plan Coinsurance.

After the applicable annual Deductible is satisfied, Members may be required to pay Plan Coinsurance for Covered Services.

3. Copayments.

Members shall be required to pay applicable Copayments at the time of service. Payment of a Copayment does not exclude the possibility of an additional billing if the service is determined to be a non-Covered Service or if other Cost Shares apply.

4. Out-of-pocket Limit.

Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV. Total Out-of-pocket Expenses incurred during the same calendar year shall not exceed the Out-of-pocket Limit.

C. Financial Responsibilities for Non-Covered Services.

The cost of non-Covered Services and supplies is the responsibility of the Member. The Contract Holder is liable for payment of any fees charged for non-Covered Services provided to the Contract Holder and his/her Dependents at the time of service. Payment of an amount billed must be received within 30 days of the billing date.

IV. Benefits Details

Benefits are subject to all provisions of the Agreement. Members are entitled only to receive benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by Group Health's medical director and as described herein. All Covered Services are subject to case management and utilization management. Benefits available will not duplicate benefits provided under any other Group Health medical coverage Agreement. "Case management" means a care management plan developed for a Member whose diagnosis requires timely coordination.

Annual Deductible	Member pays $750 per Member per calendar year or $1,500 per Family Unit per calendar year
Coinsurance	**Plan Coinsurance:** Member pays 0%
Lifetime Maximum	No lifetime maximum on covered Essential Health Benefits
Out-of-pocket Limit	Limited to a maximum of $750 per Member or $1,500 per Family Unit per calendar year
	The following Out-of-pocket Expenses apply to the Out-of-pocket Limit: All Cost Shares for Covered Services **The following expenses do not apply to the Out-of-pocket Limit:** Premiums, charges for services in excess of a benefit, charges in excess of Allowed Amount, charges for non-Covered Services
Pre-existing Condition Waiting Period	No pre-existing condition waiting period

Acupuncture	
Acupuncture needle treatment, limited to 12 visits per calendar year. Preauthorization is not required. No visit limit for treatment for Chemical Dependency.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Herbal supplements; reflexology; any services not within the scope of the practitioner's licensure	

Allergy Services	
Allergy testing.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Allergy serum and injections.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Cancer Screening and Diagnostic Services	
Routine cancer screening covered as Preventive Services in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service. See Preventive Services for additional information.	No charge; Member pays nothing
Diagnostic laboratory, diagnostic procedures (including colonoscopies, cardiovascular testing, pulmonary function studies, and neurology/neuromuscular procedures) and diagnostic services for cancer. See Laboratory and Radiology for additional information. Preventive laboratory/radiology services are covered as Preventive Services.	After Deductible, Member pays nothing

Cardiac Rehabilitation	
Cardiac rehabilitation is covered when clinical criteria is met. Preauthorization is required.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits

	All other services, including surgical services: After Deductible, Member pays nothing

Chemical Dependency	
Chemical dependency services including, treatment provided in an outpatient or home health setting, and inpatient Residential Treatment; diagnostic evaluation and education; organized individual and group counseling; and/or prescription drugs unless excluded under Sections IV. or V. Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the user's health is substantially impaired or endangered or his/her social or economic function is substantially disrupted. For the purposes of this section, the definition of Medically Necessary shall be expanded to include those services necessary to treat a chemical dependency condition that is having a clinically significant impact on a Member's emotional, social, medical and/or occupational functioning. Chemical dependency services must be provided at a Group Health-approved treatment facility or treatment program. Chemical dependency services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57), a psychologist (licensed under RCW 18.83), a chemical dependency treatment program licensed for the service being provided by the Washington State Department of Social and Health Services (pursuant to RCW 70.96A), a master's level therapist (licensed under RCW 18.225.090), an advance practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. Court-ordered chemical dependency treatment shall be covered only if determined to be Medically Necessary. Residential treatment and non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Acute chemical withdrawal (detoxification) services for alcoholism and drug abuse. "Acute chemical withdrawal" means withdrawal of alcohol and/or drugs from a Member for whom consequences of abstinence are so severe that they require medical/nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the Member's health. Coverage for acute chemical withdrawal (detoxification) is	**Emergency Services Network Facility:** After Deductible, Member pays nothing **Emergency Services Non-Network Facility:** After Deductible, Member pays nothing **Hospital - Inpatient:** After Deductible, Member pays nothing

provided without Preauthorization. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Group Health reserves the right to require transfer of the Member to a Network Facility/program upon consultation between a Network Provider and the attending physician. If the Member refuses transfer to a Network Facility/program, all further costs incurred during the hospitalization are the responsibility of the Member.	
Exclusions: Experimental or investigational therapies, such as wilderness therapy; facilities and treatments programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State; services provided which do not meet notification requirements	

Circumcision	
Circumcision. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Clinical Trials	
Notwithstanding any other provision of this document, the Plan provides benefits for Routine Patient Costs of qualified individuals in approved clinical trials, to the extent benefits for these costs are required by federal or state law. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical Trials are a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. “Life threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Clinical trials require Preauthorization.	
Exclusions: Routine patient costs do not include: (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	

Dental Services and Dental Anesthesia	
Dental services including accidental injury to natural teeth.	Not covered; Member pays 100% of all charges
Dental services or appliances provided during medical treatment for emergent dental care, dental care which requires the extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, and oral surgery related to trauma.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing
General anesthesia services and related facility charges for dental procedures for Members who are under 9 years of age, or are physically or developmentally disabled or have a Medical Condition where the Member's health would be put at risk if the dental procedure were performed in a dentist's office. General anesthesia services for dental procedures require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing
Exclusions: Dentist's or oral surgeon's fees for non-emergent dental care, surgery, services and appliances, including: non-emergent reconstructive surgery to the jaw in preparation for dental implants, dental implants, orthodontic braces for any condition, periodontal surgery; any other dental service not specifically listed as covered	

Devices, Equipment and Supplies (for home use)	
• Durable medical equipment: Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and is used in the Member's home. Durable medical equipment includes hospital beds, wheelchairs, walkers, crutches, canes, braces and splints, blood glucose monitors, external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), oxygen and oxygen equipment, and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. Group Health will determine if equipment is made available on a rental or purchase basis. • Orthopedic appliances: Items attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function. • Orthotic devices.	After Deductible, Member pays nothing

• Ostomy supplies: Supplies for the removal of bodily secretions or waste through an artificial opening. • Post-mastectomy bras/forms, limited to 2 every 6 months. Replacements within this 6 month period are covered when Medically Necessary due to a change in the Member's condition. • Prosthetic devices: Items which replace all or part of an external body part, or function thereof. • Sales tax for devices, equipment and supplies. When provided in lieu of hospitalization, benefits will be the greater of benefits available for devices, equipment and supplies, home health or hospitalization. See Hospice for durable medical equipment provided in a hospice setting. Devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment require Preauthorization.	
Exclusions: Arch supports, including custom shoe modifications or inserts and their fittings not related to the treatment of diabetes; orthopedic shoes that are not attached to an appliance; wigs/hair prosthesis; take-home dressings and supplies following hospitalization; supplies, dressings, appliances, devices or services not specifically listed as covered above; same as or similar equipment already in the Member's possession; replacement or repair due to loss, theft, breakage from willful damage, neglect or wrongful use, or due to personal preference; structural modifications to a Member's house or personal vehicle	

Diabetic Education, Equipment and Pharmacy Supplies	
Diabetic education and training.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Diabetic equipment: Blood glucose monitors and external insulin pumps (including related supplies such as tubing, syringe cartridges, cannulae and inserters), and therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays nothing
Diabetic pharmacy supplies: Insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles, glucagon emergency kits, prescriptive oral agents and blood glucose test strips for a supply of 30 days or less per item. Certain brand name insulin drugs will be covered at the generic level. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $7 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment per 30-days up to a 90-day supply **Non-Preferred generic, brand name and specialty drugs (Tier 3):** Not covered; Member pays 100% of all charges

	Preferred specialty drugs (Tier 4): After Deductible, Member pays 40% coinsurance up to a 30-day supply
Diabetic retinal screening.	No charge; Member pays nothing

Dialysis (Home and Outpatient)	
Dialysis in an outpatient or home setting is covered for Members with acute kidney failure or end-stage renal disease (ESRD). Dialysis requires Preauthorization.	**Hospital – Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Injections administered by a professional in a clinical setting during dialysis.	**Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Self-administered injectables. See Drugs – Outpatient Prescription for additional pharmacy information.	**Preferred generic drugs (Tier 1):** Member pays $7 Copayment per 30-day up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment per 30-days up to a 90-day supply **Non-Preferred generic, brand name and specialty drugs (Tier 3):** Not covered; Member pays 100% of all charges **Preferred specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply

Drugs - Outpatient Prescription	
Prescription drugs, supplies and devices for a supply of 30 days or less including diabetic pharmacy supplies (insulin, lancets, lancet devices, needles, insulin syringes, insulin pens, pen needles and blood glucose test strips), mental health drugs, self-administered injectables, teaching doses of self-administered injections, limited to 3 doses per medication per lifetime, and routine costs for prescription medications	**Preferred generic drugs (Tier 1):** Member pays $7 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $30 Copayment per 30-days up to a 90-day supply

provided in a clinical trial. “Routine costs” means items and services delivered to the Member that are consistent with and typically covered by the plan or coverage for a Member who is not enrolled in a clinical trial. All drugs, supplies and devices must be for Covered Services. All drugs, including specialty drugs, supplies and devices must be obtained at a Group Health-designated pharmacy except for drugs dispensed for Emergency services or for Emergency services obtained outside of the Group Health Service Area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory, or can be obtained by contacting the Group Health Customer Service Center. Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services when obtained with a prescription. A list of these drugs are available at www.ghc.org. Certain drugs are subject to Preauthorization as shown in the Preferred drug list (formulary) available at www.ghc.org.	**Non-Preferred generic, brand name and specialty drugs (Tier 3):** Not covered; Member pays 100% of all charges **Preferred specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply
Injections administered by a professional in a clinical setting.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Over-the-counter drugs not included under Preventive Care.	Not covered; Member pays 100% of all charges
Mail order drugs dispensed through the Group Health-designated mail order service.	**Preferred generic drugs (Tier 1):** Member pays $2 Copayment per 30-days up to a 90-day supply **Preferred brand name drugs (Tier 2):** Member pays $25 Copayment per 30 days up to a 90-day supply **Non-Preferred generic, brand name and specialty drugs (Tier 3):** Not covered; Member pays 100% of all charges **Preferred specialty drugs (Tier 4):** After Deductible, Member pays 40% coinsurance up to a 30-day supply
The Group Health Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products	

and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs.

A Member, a Member's designee, or a prescribing physician may request a coverage exception to gain access to clinically appropriate drugs if the drug is not otherwise covered by contacting Customer Service. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits. Group Health will provide a determination and notification of the determination no later than 72 hours from the non-urgent request after receipt of information sufficient to make a decision. The prescribing physician must submit an oral or written statement regarding the need for the non-Preferred drug, and a list of all of the preferred drugs which have been ineffective for the Member. If coverage of a Non-preferred drug is approved, the drug will be covered at the Preferred drug level.

Expedited or Urgent Reviews: A Member, a Member's designee, or a prescribing physician may request an expedited review for coverage for non-covered drugs when a delay caused by using the standard review process will seriously jeopardize the Member's life, health or ability to regain maximum function or will subject to the Member to severe pain that cannot be managed adequately without the requested drug. Group Health or the IRO will provide a determination and notification of the determination no later than 24 hours after the receipt of the request after receipt of information sufficient to make a decision.

Notification of Determination: If coverage is approved, Group Health will notify the prescribing physician of the determination. If coverage is denied, Group Health will provide notification of the adverse determination to the prescribing physician and the member.

External Exception Review: If an exception is not authorized for a non-formulary drug, a Member, a Member's designee, or a prescribing physician may request a second level exception denial review by an external independent review. Organization (IRO) not legally affiliated with or controlled by Group Health. The IRO will provide its determination to the Member, Member designee and the prescribing physician no later than 72 hours of receipt of the request after receipt of information sufficient to make a decision. For expedited reviews, the IRO will provide a determination no later than 24 hours after the receipt of the request after receipt of information sufficient to make a decision.

Prescription drugs are drugs which have been approved by the Food and Drug Administration (FDA) and which can, under federal or state law, be dispensed only pursuant to a prescription order. These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Standard reference compendia" means the American Hospital Formulary Service – Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia – Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Generic drugs are dispensed whenever available. A generic drug is a drug that is therapeutically equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. Brand name drugs are dispensed if there is not a generic equivalent. In the event the Member elects to purchase a brand-name drug instead of the generic equivalent (if available), the Member is responsible for paying the difference in cost in addition to the prescription drug Cost Share.

Drug coverage is subject to utilization management that includes Preauthorization, step therapy (when a Member tries a certain medication before receiving coverage for a similar, but non-Preferred medication), limits on drug quantity or days supply and prevention of overutilization, underutilization, therapeutic duplication, drug-drug interactions,

incorrect drug dosage, drug-allergy contraindications and clinical abuse/misuse of drugs. If a Member has a new prescription for a chronic condition, the member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity. The Member pays one-half of the Copayment if a supply of 15 days or less of the prescription is filled. There is no prorated Copayment if 16 – 30 days supply of the prescription is filled. The Member is charged 1.5 times the Copayment for a supply of more than 30 days. Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through Group Health's preferred specialty vendor and/or network of specialty pharmacies. For a list of specialty drugs or more information about Group Health's specialty pharmacy network, please go to the Group Health website at www.ghc.org or contact Customer Service at 206-901-6924 or toll-free at 1-800-290-8900.
The Member's Right to Safe and Effective Pharmacy Services: State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee Members' right to know what drugs are covered and the coverage limitations. Members who would like more information about the drug coverage policies, or have a question or concern about their pharmacy benefit, may contact Group Health at 206-901-6924 or toll-free 1-800-290-8900 or by accessing the Group Health website at www.ghc.org. Members who would like to know more about their rights under the law, or think any services received while enrolled may not conform to the terms of the Agreement, may contact the Washington State Office of Insurance Commissioner at toll-free 1-800-562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the Washington State Department of Health at toll-free 1-800-525-0127.
Prescription Drug Coverage and Medicare: This benefit, for purposes of Creditable Coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. Members who are also eligible for Medicare Part D can remain covered and will not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D plan at a later date; however, the Member could be subject to payment of higher Part D premiums if the Member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan. A Member who discontinues coverage must meet eligibility requirements in order to re-enroll.
Exclusions: Over-the-counter drugs (including prescription drugs that have an over-the-counter equivalent), supplies and devices not requiring a prescription under state law or regulations, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF); drugs and injections for anticipated illness while traveling; drugs and injections for cosmetic purposes; replacement of lost or stolen drugs or devices; administration of excluded drugs and injectables; drugs used in the treatment of sexual dysfunction disorders; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency; prescription drugs/products available over-the-counter or have an over-the-counter alternative that is determined to be therapeutically interchangeable

Emergency Services	
Emergency services at a Network Facility or non-Network Facility. See Section XII. for a definition of Emergency. Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any	**Network Facility:** After Deductible, Member pays nothing **Non-Network Facility:** After Deductible, Member pays nothing

admission, or as soon thereafter as medically possible. If a Member is admitted as an inpatient directly from an emergency department, any Emergency services Copayment is waived. Coverage is subject to the hospital services Cost Share. If a Member is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility upon consultation between a Network Provider and the attending physician. If the Member refuses to transfer to a Network Facility or does not notify Group Health within 24 hours following admission, all further costs incurred during the hospitalization are the responsibility of the Member. Follow-up care which is a direct result of the Emergency must be received from a Network Provider, unless Preauthorization is obtained for such follow-up care from a non-Network Provider.	
Ambulance Emergency ground or air transport to any facility, including treatment included as part of the ambulance service.	After Deductible, Member pays nothing
Ambulance non-Emergency ground or air interfacility transfer to or from a Network Facility when initiated by Group Health.	After Deductible, Member pays nothing **Hospital to hospital transfers:** No charge; Member pays nothing

Hearing Examinations and Hearing Aids	
Cochlear implants when in accordance with Group Health clinical criteria. Covered services for cochlear implants include implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries). Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants are covered only when provided at Group Health-approved facilities.	**Hospital – Inpatient:** After Deductible, Member pays nothing **Hospital – Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Hearing care, routine hearing examinations, programs or treatments for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them other than for cochlear implants, and hearing screening tests required under Preventive Services	

Home Health Care	
Home health care when the following criteria are met, limited	After Deductible, Member pays nothing

to 130 visits per calendar year: • Except for patients receiving palliative care services, the Member must be unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home. • The Member requires intermittent skilled home health care, as described below. • Group Health's medical director determines that such services are Medically Necessary and are most appropriately rendered in the Member's home. Covered Services for home health care may include the following when rendered pursuant to a Group Health-approved home health care plan of treatment: nursing care; restorative physical, occupational, respiratory and speech therapy; durable medical equipment, medical social worker and limited home health aide services. Home health services are covered on an intermittent basis in the Member's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider. Home health care requires Preauthorization.	
Exclusions: Private duty nursing; housekeeping or meal services; any care provided by or for a family member; any other services rendered in the home which do not meet the definition of skilled home health care above	

Hospice	
Hospice care when provided by a licensed hospice care program. A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a Member and any family members who are caring for the Member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the Member and their family during the final stages of illness. In order to qualify for hospice care, the Member's provider must certify that the Member is terminally ill and is eligible for hospice services. **Inpatient Hospice Services.** For short-term care, inpatient hospice services are covered with Preauthorization.	No charge; Member pays nothing

Respite care is covered to provide continuous care of the Member and allow temporary relief to family members from the duties of caring for the Member on an inpatient or outpatient basis for a maximum of 14 days per lifetime. **Other covered hospice services, when billed by a licensed hospice program, may include the following:** • Inpatient and outpatient services and supplies for injury and illness. • Semi-private room and board, except when a private room is determined to be necessary. • Durable medical equipment, when billed by a licensed hospice program. Hospice care requires Preauthorization.	
Exclusions: Private duty nursing; financial or legal counseling services; meal services; any services provided by family members	

Hospital - Inpatient and Outpatient	
The following inpatient medical and surgical services are covered: • Room and board, including private room when prescribed, and general nursing services. • Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services). • Drugs and medications administered during confinement. • Medical implants. • Acute chemical withdrawal (detoxification). Outpatient hospital includes ambulatory surgical centers. Outpatient services include: • Outpatient medical and surgical care • Anesthesia and anesthesia services • Surgical dressings and supplies • Facility costs Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization or other Medically Necessary institutional care with the consent of the Member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Such care is covered to the same extent the replaced Hospital Care is covered. Alternative care arrangements require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing

Members receiving the following nonscheduled services are required to notify Group Health by way of the Group Health Hospital notification line within 24 hours following any admission, or as soon thereafter as medically possible: acute chemical withdrawal (detoxification) services, Emergency psychiatric services, Emergency services, labor and delivery and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until Preauthorization can be obtained. Coverage for Emergency services in a non-Network Facility and subsequent transfer to a Network Facility is set forth in Emergency Services. Non-Emergency inpatient hospital services require Preauthorization.	
Exclusions: Take home drugs, dressings and supplies following hospitalization; internally implanted insulin pumps and any other implantable device that have not been approved by Group Health's medical director	

Infertility (including sterility)	
Services to diagnose infertility conditions.	Office visits: After Deductible, Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Treatment and prescription drugs.	Not covered; Member pays 100% of all charges
Exclusions: Medical treatment of sterility and infertility regardless of origin or cause; all charges and related services for donor materials; all forms of artificial intervention for any reason including artificial insemination and in-vitro fertilization; genetic testing for the detection of congenital and heritable disorders; surrogacy; and any devices, equipment and supplies related to the treatment of infertility	

Infusion Therapy	
Medically Necessary infusion therapy includes, but is not limited to: • Antibiotics. • Hydration. • Chemotherapy. • Pain management.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Associated infused medications.	After Deductible, Member pays nothing

Laboratory and Radiology	
Nuclear medicine, radiology, ultrasound and laboratory services, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to Preauthorization except when associated with Emergency services or inpatient services. Please contact Customer Service for any questions regarding these services. Services received as part of an emergency visit are covered as Emergency Services. Preventive laboratory and radiology services are covered in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.	After Deductible, Member pays nothing

Manipulative Therapy	
Manipulative therapy of the spine and extremities when in accordance with Group Health clinical criteria, limited to a total of 10 visits per calendar year.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the Member; care rendered on a non-acute, asymptomatic basis; charges for any other services that do not meet Group Health clinical criteria as Medically Necessary	

Maternity and Pregnancy	
Maternity care and pregnancy services, including care for complications of pregnancy, in utero treatment for the fetus, prenatal testing for the detection of congenital and heritable disorders and prenatal and postpartum care are covered for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including breastfeeding support, supplies and counseling for each birth when Medically Necessary as determined by Group Health's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Delivery, care for complications of pregnancy and associated Hospital Care, including home births and Medically Necessary supplies for the home birth, and birthing centers. Home births are considered outpatient services.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. The Member's physician, in consultation with the Member, will determine the Member's length of inpatient stay following delivery.	
Termination of pregnancy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** No charge; Member pays nothing **Hospital - Outpatient:** No charge; Member pays nothing **Outpatient Services:** No charge; Member pays nothing
Exclusions: Birthing tubs; genetic testing of non-Members; fetal ultrasound in the absence of medical indications	

Mental Health	
Mental health services provided at the most clinically appropriate and Medically Necessary level of mental health care intervention as determined by Group Health's medical director. Treatment may utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives. Mental health services including medical management and prescriptions are covered the same as for any other condition. Behavioral treatment for a DSM category diagnosis. Eating disorder treatment provided on an inpatient or outpatient basis must be Medically Necessary and the treatment program must meet clinical criteria standards. The inpatient mental health benefit can only be used if a Member with an eating disorder also meets clinical criteria for inpatient psychiatric care. Applied behavioral analysis (ABA) therapy, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism. Documented diagnostic assessments, individualized treatment plans and progress evaluations are required. Partial hospitalization is covered subject to Hospital - Outpatient Cost Shares. Services for any involuntary court-ordered treatment program shall be covered only if determined to be Medically Necessary by Group Health's medical director. Services provided under involuntary commitment statutes are covered only at Group Health-approved facilities.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing **Group Sessions:** No charge; Member pays nothing

Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency services benefit. Members must notify Group Health by way of the Group Health Hospital notification line within 24 hours of any admission, or as soon thereafter as medically possible. Mental health services rendered to treat mental disorders are covered. Mental Disorders means mental disorders covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, except as otherwise excluded under Sections IV. or V. Mental Health Services means Medically Necessary outpatient services, Residential Treatment, partial hospitalization program, and inpatient services provided by a licensed facility or licensed providers, except as otherwise excluded under Section IV. or V. Medically Necessary mental health services provided in an outpatient and home health setting. Mental health services are covered when Medically Necessary for treatment of parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria unless preempted by federal law. Medically Necessary inpatient mental health services, partial hospitalization programs, and residential treatment must be provided at a hospital or facility that Group Health has approved specifically for the treatment of mental disorders. Chemical dependency services are covered subject to the Chemical Dependency services benefit. Non-Emergency inpatient hospital services, including Residential Treatment and partial hospitalization programs, require Preauthorization.	
Exclusions: Academic or career counseling; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including reports and summaries, not considered Medically Necessary; work or school ordered assessment and treatment not considered Medically Necessary; counseling for overeating not considered Medically Necessary; specialty treatment programs such as “behavior modification programs” not considered Medically Necessary; parent-child relational problems for children six years of age and older; neglect or abuse counseling for individuals six years of age or older; bereavement counseling for individuals six years of age or older; counseling for relational or phase of life problems; custodial care	

Naturopathy	
Naturopathy. Laboratory and radiology services are covered only when obtained through a Network Facility.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits

	All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Herbal supplements; nutritional supplements; any services not within the scope of the practitioner's licensure	

Newborn Services	
Newborn services, including nursery services and supplies, are covered the same as for any other condition. Any Cost Share for newborn services is separate from that of the mother. Preventive services for newborns are covered under Preventive Services. See Section VI.A.3. for information about temporary coverage for newborns. Newborn services care covered for newly adopted children.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Nutritional Counseling	
Nutritional counseling. Nutritional counseling is not subject to visit limitations. Services related to a healthy diet to prevent obesity are covered as Preventive Services.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Nutritional supplements; weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such programs; pre and post bariatric surgery nutritional counseling	

Nutritional Therapy	
Dietary formula for the treatment of phenylketonuria (PKU).	No charge; Member pays nothing
Enteral therapy (elemental formulas) for malabsorption and an eosinophilic gastrointestinal associated disorder. Necessary equipment and supplies for the administration of enteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays nothing
Parenteral therapy (total parenteral nutrition). Necessary equipment and supplies for the administration of parenteral therapy are covered as Devices, Equipment and Supplies.	After Deductible, Member pays nothing

Exclusions: Any other dietary formulas or medical foods; oral nutritional supplements; special diets; and prepared foods/meals

Obesity Related Services	
Services directly related to obesity, including bariatric surgery. Services related to obesity screening and counseling are covered as Preventive Services.	Not covered; Member pays 100% of all charges
Exclusions: Obesity treatment and treatment for morbid obesity for any reason including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, except as described above; specialty treatment programs such as weight control self-help programs or memberships, such as Weight Watchers, Jenny Craig, or other such; medications and related physician visits for medication monitoring; pre and post bariatric surgery nutritional counseling	

Oncology	
Radiation therapy, chemotherapy, oral chemotherapy. See Infusion Therapy for infused medications.	**Oral Chemotherapy Drugs:** After Deductible, Member pays $10 Copayment per 30-days up to a 90 day supply for Preferred generic and brand name drugs **Radiation Therapy and Chemotherapy:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Optical (adult vision)	
Members age 19 and over – routine eye examinations and refractions, limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits **Exams for Eye Pathology:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

Contact lenses or framed lenses for eye pathology when Medically Necessary. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the Member has been continuously covered by Group Health since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription.	**Frames and Lenses:** Not covered; Member pays 100% of all charges **Contact Lenses or framed lenses for Eye Pathology:** After Deductible, Member pays nothing
Exclusions: Eyeglasses; contact lenses, contact lens evaluations, fittings and examinations not related to eye pathology; orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Optical (pediatric vision)	
Members to age 19 – Routine eye examinations and refractions, coverage is limited to one per calendar year. Eye and contact lens examinations for eye pathology and to monitor Medical Conditions when Medically Necessary.	**Routine Exams:** No charge; Member pays nothing **Exams for Eye Pathology:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Members to age 19 – Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting. The benefit period begins on January 1 and continues through the end of the calendar year. The benefit may be used toward any of the following combination: contact lenses (in lieu of eyeglasses) or 1 eyeglass frame and pair of lenses in any of the following combinations: • Eyeglass frames • Eyeglass lenses (any type) including tinting and coating • Corrective industrial (safety) lenses • Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations Contact lenses or framed lenses for eye pathology when Medically Necessary. Note: Disposable contact lenses are available up to a 1 year supply as prescribed by the Member's provider. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the	**Frames and Lenses:** No charge; Member pays nothing for 1 set of frames and lenses (or contact lenses in lieu of eyeglasses) per calendar year **Contact Lenses or framed lenses for Eye Pathology after benefit is exhausted:** After Deductible, Member pays nothing **After benefit is exhausted and there is no eye pathology indicated:** Not covered; Member pays 100% of all charges

Member has been continuously covered by Group Health since such surgery. In the event a Member's age or medical condition prevents the Member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12 month period and only when needed due to a change in the Member's prescription. Replacement for loss or breakage is subject to the frames and lenses benefit.	
Low vision evaluation and treatment including: • One comprehensive low vision evaluation every 5 years • Visual aids and devices such as high power spectacles, magnifiers and telescopes as Medically Necessary • Four follow-up care visits for low vision services in a 5 year period Low vision services require Preauthorization.	**Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Orthoptic therapy (i.e. eye training); evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures	

Oral Surgery	
Reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or non-dental cysts of the jaw, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. Group Health's medical director will determine whether the care or treatment required is within the category of Oral Surgery or Dental Services. Oral surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Care or repair of teeth or dental structures of any type; tooth extractions or impacted teeth; services related to malocclusion; services to correct the misalignment or malposition of teeth; any other services to the mouth, facial bones or teeth which are not medical in nature	

Outpatient Services	
Covered outpatient medical and surgical services in a provider's office including, but not limited to: blood, blood products and blood storage, chronic disease management, routine costs during clinical trials, therapeutic injections, supplies, and Medically Necessary genetic testing. See Preventive Services for additional information related to chronic disease management.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing

All other services performed in the office, not billed as an office visit, or that are not related to the actual visit (separate surgical services or laboratory/radiology fees billed in conjunction with the office visit, for example) are not considered an office visit. See Hospital - Inpatient and Outpatient for outpatient hospital medical and surgical services, including ambulatory surgical centers.	

Plastic and Reconstructive Surgery	
Plastic and reconstructive services: • Correction of a congenital disease or congenital anomaly in newborns and dependent children. • Correction of a Medical Condition following an injury or resulting from surgery which has produced a major effect on the Member's appearance, when in the opinion of Group Health's medical director such services can reasonably be expected to correct the condition. • Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed. Members are covered for all stages of reconstruction on the non-diseased breast to produce a symmetrical appearance. Complications of covered mastectomy services, including lymphedemas, are covered. Plastic and reconstructive surgery requires Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services	

Podiatry	
Medically Necessary foot care. Routine foot care covered when such care is directly related to the treatment of diabetes and other clinical conditions that affect sensation and circulation to the feet.	Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: All other routine foot care	

Preventive Services	
Preventive services in accordance with the well care schedule established by Group Health. The well care schedule is available in Group Health medical centers, at www.ghc.org,	No charge; Member pays nothing

or upon request from Customer Service. Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF). Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians. Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines. Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices. Preventive services include, but are not limited to, well adult and well child physical examinations; immunizations and vaccinations; female sterilization; FDA-approved contraceptive drugs, devices, including device removal, and counseling; preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription; pap smears; routine mammography screening, routine prostate cancer screening, colorectal cancer screening for Members who are age 50 or older or who are under age 50 and at high risk, obesity screening/counseling, healthy diet, and physical activity counseling; depression screening in adults, including maternal depression. Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support. Services provided during a preventive services visit, including laboratory services, which are not in accordance with the Group Health well care schedule are subject to Cost Shares. Eye refractions are not included under preventive services.	
Exclusions: Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes that are not deemed Medically Necessary by Group Health for early detection of disease; diagnostic services	

Rehabilitation and Habilitative Care (massage, occupational, physical and speech therapy) and Neurodevelopmental Therapy	
Rehabilitation services to restore function following illness, injury or surgery, limited to the following restorative therapies: occupational therapy, physical therapy, massage	**Hospital - Inpatient:** After Deductible, Member pays nothing

therapy and speech therapy. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that may include a physician, nurse, physical therapist, occupational therapist, massage therapist or speech therapist. Rehabilitation care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Habilitative care, including: occupational therapy, physical therapy, speech therapy, aural therapy, and health care devices is covered when prescribed by a physician. Habilitative care is limited to a combined total of 30 inpatient days and 25 outpatient visits per calendar year. Outpatient services include services provided by a school district that are not delivered pursuant to the Individuals with Disabilities Education Act (IDEA) or an Individual Education Plan (IEP). Treatments for cancer, pulmonary or respiratory disease, and other chronic conditions are not included under rehabilitative or habilitative care. Services with mental health diagnoses are covered with no limit. Neurodevelopmental therapy to restore or improve function including maintenance in cases where significant deterioration in the Member's condition would result without the services, limited to the following therapies: occupational therapy, physical therapy and speech therapy. There is no visit limit for neurodevelopmental therapy services. Non-Emergency inpatient hospital services and massage therapy require Preauthorization.	**Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Specialty treatment programs; specialty rehabilitation programs including "behavior modification programs"; recreational, life-enhancing, relaxation or palliative therapy	

Sexual Dysfunction	
Sexual dysfunction services.	Not covered; Member pays 100% of all charges
Exclusions: Diagnostic testing and medical treatment of sexual dysfunction regardless of origin or cause; devices, equipment and supplies for the treatment of sexual dysfunction	

Skilled Nursing Facility	
Skilled nursing care in a skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, limited to a total of 60 days per calendar year. Care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; services provided by a licensed behavioral health provider, and short-term restorative occupational therapy, physical therapy and speech therapy. Skilled nursing care in a skilled nursing facility requires Preauthorization.	After Deductible, Member pays nothing
Exclusions: Personal comfort items such as telephone and television; rest cures; domiciliary or Convalescent Care	

Sterilization	
Female sterilization procedures. See Preventive Services for additional information. Non-Emergency inpatient hospital services require Preauthorization.	No charge; Member pays nothing
Vasectomy. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Procedures and services to reverse a sterilization	

Telemedicine	
Telemedicine services provided by the use of real time interactive audio and video communication or time delayed transmission of medical information between the patient at the originating site and a provider at another location for diagnosis, consultation, or treatment. Services must be provided by a Washington state licensed physician.	**Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits

	All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Audio-only; telephone; fax and e-mail	

Temporomandibular Joint (TMJ)	
Medical and surgical services and related hospital charges for the treatment of temporomandibular joint (TMJ) disorders including: • Orthognathic surgery for the treatment of TMJ disorders. • Radiology services. • TMJ specialist services. • Fitting/adjustment of splints. Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
TMJ appliances. See Devices, Equipment and Supplies for additional information.	After Deductible, Member pays nothing
Exclusions: Treatment for cosmetic purposes; bite blocks; dental services including orthodontic therapy and braces for any condition; any orthognathic (jaw) surgery in the absence of a diagnosis of TMJ, severe obstructive sleep apnea; hospitalizations related to these exclusions	

Tobacco Cessation	
Individual/group counseling and educational materials.	No charge; Member pays nothing
Approved pharmacy products. See Drugs – Outpatient Prescription for additional pharmacy information.	No charge; Member pays nothing

Transgender Services	
Medically Necessary medical and surgical services for gender reassignment. Prescription drugs are covered the same as for any other condition (see Drugs – Outpatient Prescription for coverage). Counseling services are covered the same as for any other condition (see Mental Health for coverage). Non-Emergency inpatient hospital services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After

	Deductible, Member pays nothing
Exclusions: Cosmetic services including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services; travel	

Transplants	
Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, liver transplants, and bone marrow and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following: • Inpatient and outpatient medical expenses for evaluation testing to determine recipient candidacy, donor matching tests, hospital charges, procurement center fees, professional fees, travel costs for a surgical team and excision fees. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees. • Follow-up services for specialty visits. • Rehospitalization. • Maintenance medications during an inpatient stay. Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendation. Transplant services require Preauthorization.	**Hospital - Inpatient:** After Deductible, Member pays nothing **Hospital - Outpatient:** After Deductible, Member pays nothing **Outpatient Services:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing
Exclusions: Donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; transportation expenses except as covered as Ambulance Services	

Urgent Care	
Inside the Group Health Service Area, urgent care is covered at a Group Health medical center, Group Health urgent care center or Network Provider's office. Outside the Group Health Service Area, urgent care is covered at any medical facility. Urgent care includes provider services, facility costs and supplies. See Section XII. for a definition of Urgent Condition.	**Network Emergency Department:** After Deductible, Member pays nothing **Network Urgent Care Center:** Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits All other services, including surgical services: After Deductible, Member pays nothing **Network Provider's Office:** Office visits: Member pays $5 Copayment for primary care provider office visits or $10 Copayment for specialty care provider office visits

	All other services, including surgical services: After Deductible, Member pays nothing **Outside the Group Health Service Area:** After Deductible, Member pays nothing

Virtual Care	
Healthcare service provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (ex. home) with an in-network provider that is diagnostic and treatment focused. The Member is NOT located at a healthcare site.	No charge; Member pays nothing

V. General Exclusions

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

1. Benefits and related services, supplies and drugs that are not Medically Necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered in the Agreement, except as required by federal or state law.

2. Follow-up services or complications related to non-Covered Services, except as required by federal or state law.

3. Services or supplies for which no charge is made, or for which a charge would not have been made if the Member had no health care coverage or for which the Member is not liable; services provided by a family member, or self-care.

4. Convalescent Care.

5. Services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, pursuant to medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member receives benefits under the policy either as a named insured or as an insured individual under the policy definition of insured.

6. Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.

7. Services provided by government agencies, except as required by federal or state law.

8. Services covered by the national health plan of any other country.

9. Experimental or investigational services.

   Group Health consults with Group Health's medical director and then uses the criteria described below to decide if a particular service is experimental or investigational.

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

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

Appeals regarding Group Health denial of coverage can be submitted to the Member Appeal Department, or to Group Health's medical director at P.O. Box 34593, Seattle, WA 98124-1593.

10. Hypnotherapy and all services related to hypnotherapy.

11. Directed umbilical cord blood donations.

12. Prognostic (predictive) genetic testing and related services, unless specifically provided in Section IV. Testing for non-Members.

13. Autopsy and associated expenses.

14. Job skills training for specific occupations or educational therapy.

15. Expenses for services and supplies incurred as a result of any work-related injury or illness. This includes individuals who are partners, proprietors or corporate officers who are not covered by a Workers' Compensation Act or other similar law.

VI. Eligibility, Enrollment and Termination

A. Eligibility.
In order to be accepted for enrollment and continuing coverage, individuals are eligible as set forth below.

1. Contract Holders.
Must establish and maintain permanent residency in the Group Health Service Area for duration of enrollment.

2. Dependents.
The Contract Holder may also enroll the following:

a. The Contract Holder's legal spouse; or

b. The Contract Holder's state-registered domestic partner (as required by Washington state law); or the Contract Holder's non-state registered domestic partner provided that application has been submitted to approved by Group Health.

c. The Contract Holder's children who are under the age of 26.

"Children" means the children of the Contract Holder, spouse or eligible domestic partner, including adopted children, stepchildren, children for whom the Contract Holder has a qualified court order to provide coverage.

Eligibility may be extended past the Dependent's limiting age for a person enrolled as a Dependent on his/her 26th birthday if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred while eligible and enrolled under the Agreement, and is chiefly dependent upon the Contract Holder for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependency must be submitted to Group Health within 31 days of the date a Dependent reaches the limiting age. Proof must also be furnished to Group Health upon request, but not more frequently than annually after the 2 year period following the Dependent's attainment of the limiting age.

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

4. Other Group Health Individual and Family Plans.
A Contract Holder enrolled on this Individual and Family Plan who subsequently wishes to change coverage for him/herself and his/her family Dependent(s) to another Individual and Family Plan may change to any other open Individual and Family Plan, provided that all premium, Out-of-Pocket Expenses and charges incurred for non-Covered Services are paid in full during the annual open enrollment periods or during a special enrollment period as long as they meet a qualifying event.

5. Ineligible Persons.

a. Persons may not be enrolled under more than one individual Group Health medical coverage Agreement at the same time.

b. Persons may not enroll in this plan who are enrolled for benefits under the Federal Medicare program.

c. Group Health reserves the right to refuse enrollment to any persons whose coverage under any medical coverage Agreement issued by Group Health Cooperative or Group Health Options, Inc. has been terminated for nonpayment or cause, as set forth in Subsection E. below.

B. Application for Enrollment.

Application for enrollment and adding or removing dependents must be made on an application approved by Group Health or through the Washington Health Benefit Exchange, as applicable for the Member's type of plan. Under the federal Patient Protection and Affordable Care Act of 2010, you cannot be denied health insurance but coverage must be purchased during a limited period of time. Special enrollment periods may apply if there is a qualifying event. If one of the qualifying events listed below occurs, you have 60 days to buy coverage. The following qualifying events apply to all individual health plans:

- Loss of health coverage, including an employer plan.
- Loss of Apple Health (Medicaid) eligibility.
- Change of permanent residence outside the service area of the Member's current coverage.
- Change of permanent residence where additional health insurance plan options are available.
- Birth or adoption.
- COBRA eligibility/coverage ends.
- Dependent loss of eligibility on an employer plan due to age.
- Marriage or domestic partnership (dependents also qualify).
- Dissolution of marriage or domestic partnership.
- Discontinuation of Washington State Health Insurance Pool (WSHIP) coverage.
- Demonstrate that the health insurer violated an important provision of its contract with you, such as non-payment of claims for covered health care treatments.
- Loss of coverage due to errors made by the Washington Health Benefit Exchange.
- Become a legal resident.
- Change in income or household status that affects eligibility for tax credits or cost-sharing reductions.
- The Washington Health Benefit Exchange discontinues your coverage.
- Native American Members are allowed to change plans once a month.

In order for a person 17 years of age or younger to be enrolled, Group Health reserves the right to require a guarantor who is 18 years of age or older to cosign the Agreement.

C. When Coverage Begins.

1. Effective Date of Enrollment.

- Enrollment for a newly eligible Contract Holder and listed Dependents is effective on the date specified by Group Health or the Washington Health Benefit Exchange following acceptance by Group Health and the Member.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first of the month following the date eligibility requirements are met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Contract Holder for the purpose of adoption or the Contract Holder assumes total or partial financial support of the child.

2. Commencement of Benefits for Persons Hospitalized on Effective Date.

Members who are admitted to an inpatient facility prior to their enrollment will receive covered benefits beginning on their effective date, as set forth in Subsection C.1. above. If a Member is hospitalized in a non-Network Facility, Group Health reserves the right to require transfer of the Member to a Network Facility. The Member will be transferred when a Network Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a Network Facility, all further costs incurred during the hospitalization are the responsibility of the Member.

D. When Coverage Ends

Coverage ends on the last day of the month in which you lose eligibility, provided all premium amounts have been paid. In the case of non-payment of premium, coverage ends on the last day of the month for which premium has been received.

E. Eligibility for Medicare.

Individuals eligible for Medicare are not required to enroll in Medicare Parts A and B. An individual shall be deemed eligible for Medicare when he or she has the option to receive Part A Medicare benefits. Members who become eligible for Medicare benefits may continue coverage under the Agreement or may enroll in coverage with the Group Health Medicare Advantage Plan as follows:

1. **Continuation of Coverage under the Agreement.**
   Members who become eligible to purchase Medicare are not required to enroll in both Medicare Parts A and B to remain eligible under the Agreement, when Members continue to submit payment of the applicable premium set forth in the premium schedule.

2. **Enrollment in Group Health's Medicare Advantage Plan.**
   Medicare-eligible Members residing inside the Medicare Advantage Service Area upon enrollment in both Medicare Parts A and B may enroll in a Group Health Medicare Advantage Plan. Once the Member has transferred from an individual plan to the Medicare Advantage Plan, he/she is not eligible or entitled to re-enrollment in an individual plan. A condition of coverage under the Group Health Medicare Advantage Plan requires that a Member be continuously fully qualified and enrolled for the hospital (Part A) and medical (Part B) benefits, available from the Social Security Administration and sign any papers that may be required by Group Health or Medicare. All applicable provisions of the Group Health Medicare Advantage Plan are fully set forth in each Medicare medical coverage Agreement.

F. Termination of Coverage.

This is a guaranteed renewable Agreement and cannot be terminated except as provided in compliance with the Group Health or Washington Health Benefit Exchange terms and guidelines.

1. Non-payment of Premium
2. The Member violates published policies applicable to this Plan which have been approved by the Washington State Insurance Commissioner.
3. The Member voluntarily disenrolls from this plan.
4. The Member commits fraudulent acts.
5. The Member materially breaches the terms of this contract or fails to meet all eligibility requirements.
6. There is a change in federal or state laws that no longer permit Group Health to continue offering this Plan.
7. Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services.

G. Continuation of Inpatient Services.

A Member who is receiving Covered Services in a hospital on the date of termination shall continue to be eligible for Covered Services while an inpatient for the condition which the Member was hospitalized, until one of the following events occurs:

- According to Group Health clinical criteria, it is no longer Medically Necessary for the Member to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The Member becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The Member becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the Member is covered under another agreement that provides benefits for the hospitalization at the time coverage would terminate.

VII. Grievances

Grievance means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including

dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. The grievance process is outlined as follows:

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

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

Step 3: If the Member is still not satisfied, he/she should call Customer Service at 206-901-6924 or toll-free 1-800-290-8900. Most concerns are handled by phone within a few days. In some cases the Member will be asked to write down his/her concerns and state what he/she thinks would be a fair resolution to the problem. An appropriate representative will investigate the Member's concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of the Member's written statement.

If the Member is dissatisfied with the resolution of the complaint, he/she may contact Customer Service. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

VIII. Appeals

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the Group Health medical director. The appeals process is available for a Member to seek reconsideration of an adverse benefit determination (action). Adverse benefit determination (action) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan. Group Health will comply with any new requirements as necessary under federal laws and regulations. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. The most current information about your appeals process is available by contacting Group Health's Member Appeal Department at the address or telephone number below.

1. **Initial Appeal**
   If the Member or the Member's legal representative wishes to appeal a Group Health decision to deny, modify, reduce or terminate coverage of or payment for health care services, he/she must submit a request for an appeal either orally or in writing to Group Health's Member Appeal Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Group Health will notify the Member of its receipt of the request within 72 hours of receiving it. Appeals should be directed to Group Health's Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, toll-free 1-866-458-5479.

   A party not involved in the initial coverage determination and not a subordinate of the party making the initial coverage determination will review the appeal request. Group Health will then notify the Member of its determination or need for an extension of time within 14 days of receiving the request for appeal. Under no circumstances will the review timeframe exceed 30 days without the Member's written permission.

   For appeals involving experimental or investigational services Group Health will make a decision and communicate the decision to the Member in writing within 20 days of receipt of the appeal.

   There is an **expedited/urgent appeals process** in place for cases which meet criteria or where delay using the standard appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited/urgent appeal in writing to the above address, or by calling Group Health's Member Appeal Department toll-free 1-866-458-5479. The nature of

the patient's condition will be evaluated by a physician and if the request is not accepted as urgent, the Member will be notified in writing of the decision not to expedite and given a description on how to grieve the decision. If the request is made by the treating physician who believes the Member's condition meets the definition of expedited, the request will be processed as expedited.

The request for an expedited/urgent appeal will be processed and a decision issued no later than 72 hours after receipt of the request.

The Member may also request an external review at the same time as the internal appeals process if it is an urgent care situation or the Member is in an ongoing course of treatment.

If the Member requests an appeal of a Group Health decision denying benefits for care currently being received, Group Health will continue to provide coverage for the disputed benefit pending the outcome of the appeal. If the Group Health determination stands, the Member may be responsible for the cost of coverage received during the review period.

The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the health insurance consumer ombudsman. The Consumer Protection Division Office can be reached by mail at Washington State Insurance Commissioner, Consumer Protection Division, P.O. Box 40256, Olympia, WA 98504-0256 or at toll-free 1-800-562-6900. More information about requesting assistance from the Consumer Protection Division Office can be found at http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/.

2. **Next Level of Appeal**
   If the Member is not satisfied with the decision regarding medical necessity, medical appropriateness, health care setting, level of care, or if the requested service is not efficacious or otherwise unjustified under evidence-based medical criteria, or if Group Health fails to adhere to the requirements of the appeals process, the Member may request a second level review by an external independent review organization not legally affiliated with or controlled by Group Health. Group Health will notify the Member of the name of the external independent review organization and its contact information. The external independent review organization will accept additional written information for up to 5 business days after it receives the assignment for the appeal. The external independent review will be conducted at no cost to the Member. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health.

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

IX. Claims

Claims for benefits may be made before or after services are obtained. Group Health recommends that the provider requests Preauthorization. In most instances, contracted providers submit claims directly to Group Health. If your provider does not submit a claim, to make a claim for benefits, a Member must contact Customer Service, or submit a claim for reimbursement as described below. Other inquiries, such as asking a health care provider about care or coverage, or submitting a prescription to a pharmacy, will not be considered a claim for benefits.

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

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

- Immediate request situations – within 1 business day.
- Concurrent urgent requests – within 24 hours.

- Urgent care review requests – within 48 hours.
- Non-urgent preservice review requests – within 5 calendar days.
- Post-service review requests – within 30 calendar days.

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

X. Coordination of Benefits

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

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

If the Member is covered by more than one health benefit plan, and the Member does not know which is the primary plan, the Member or the Member's provider should contact any one of the health plans to verify which plan is primary. The health plan the Member contacts is responsible for working with the other plan to determine which is primary and will let the Member know within 30 calendar days.

All health plans have timely claim filing requirements. If the Member or the Member's provider fails to submit the Member's claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If the Member experiences delays in the processing of the claim by the primary health plan, the Member or the Member's provider will need to submit the claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

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

Definitions.

A. A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

   1. Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

   2. Plan does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans; unless permitted by law.

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

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the Member has health care coverage under more than one plan.

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

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

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

2. If a Member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

3. If a Member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

4. An expense or a portion of an expense that is not covered by any of the plans covering the person is not an allowable expense.

E. Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the plan, and that excludes coverage for services provided by other providers, except in cases of Emergency or referral by a panel member.

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

Order of Benefit Determination Rules.

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

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B. (1) Except as provided below (subsection 2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

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

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The plan that covers the Member other than as a Dependent, for example as an employee, member, policyholder, Contract Holder or retiree is the primary plan and the plan that covers the Member as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the Member as a Dependent, and primary to the plan covering the Member as other than a Dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the Member as an employee, member, policyholder, Contract Holder or retiree is the secondary plan and the other plan is the primary plan.

2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

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

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

- The plan covering the spouse of the non-custodial parent, last.

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

3. Active employee or retired or laid-off employee. The plan that covers a Member as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same Member as a retired or laid off employee is the secondary plan. The same would hold true if a Member is a Dependent of an active employee and that same Member is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Section D(1) can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member, Contract Holder or retiree or covering the Member as a Dependent of an employee, member, Contract Holder or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under Section D.1. can determine the order of benefits.

5. Longer or shorter length of coverage. The plan that covered the Member as an employee, member, Contract Holder or retiree longer is the primary plan and the plan that covered the Member the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan.

When this plan is secondary, it must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the Member be responsible for a deductible amount greater than the highest of the two deductibles.

Right to Receive and Release Needed Information.

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

Facility of Payment.

If payments that should have been made under this plan are made by another plan, Group Health has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, Group Health is fully discharged from liability under this plan.

Right of Recovery.

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

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

Effect of Medicare.

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

When a Network Provider renders care to a Member who is eligible for Medicare benefits, and Medicare is deemed to be the primary bill payer under Medicare secondary payer guidelines and regulations, Group Health will seek Medicare reimbursement for all Medicare covered services.

XI. Subrogation and Reimbursement Rights

The benefits under this Agreement will be available to a Member for injury or illness caused by another party, subject to the exclusions and limitations of this Agreement. If Group Health provides benefits under this Agreement for the treatment of the injury or illness, Group Health will be subrogated to any rights that the Member may have to recover compensation or damages related to the injury or illness and the Member shall reimburse Group Health for all benefits provided, from any amounts the Member received or is entitled to receive from any source on account of such injury or illness, whether by suit, settlement or otherwise. This section more fully describes Group Health's subrogation and reimbursement rights.

"Injured Person" under this section means a Member covered by the Agreement who sustains an injury or illness and any spouse, dependent or other person or entity that may recover on behalf of such Member including the estate of the Member and, if the Member is a minor, the guardian or parent of the Member. When referred to in this section, "Group Health's Medical Expenses" means the expenses incurred and the value of the benefits provided by Group Health under this Agreement for the care or treatment of the injury or illness sustained by the Injured Person.

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

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

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury or illness, including but not limited to any liability insurance or uninsured/underinsured motorist funds, Group Health's Medical Expenses are secondary, not primary.

The Injured Person and his/her agents shall cooperate fully with Group Health in its efforts to collect Group Health's Medical Expenses. This cooperation includes, but is not limited to, supplying Group Health with information about the cause of injury or illness, any potentially liable third parties, defendants and/or insurers related to the Injured Person's claim. The Injured Person shall notify Group Health within 30 days of any claim that may give rise to a claim for subrogation or reimbursement. The Injured Person shall provide periodic updates about any facts that may impact Group Health's right to reimbursement or subrogation as requested by Group Health, and shall inform Group Health of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit Group Health, at Group Health's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow Group Health to initiate its own direct action for reimbursement or subrogation.

The Injured Person and his/her agents shall do nothing to prejudice Group Health's subrogation and reimbursement rights. The Injured Person shall promptly notify Group Health of any tentative settlement with a third party and shall

not settle a claim without protecting Group Health's interest. The Injured Person shall provide 21 days advance notice to Group Health before there is a disbursement of proceeds from any settlement with a third party that may give rise to a claim for subrogation or reimbursement. If the Injured Person fails to cooperate fully with Group Health in recovery of Group Health's Medical Expenses, the Injured Person shall be responsible for directly reimbursing Group Health for 100% of Group Health's Medical Expenses.

To the extent that the Injured Person recovers funds from any source that in any manner relate to the injury or illness giving rise to Group Health's right of reimbursement or subrogation, the Injured Person agrees to hold such monies in trust or in a separate identifiable account until Group Health's subrogation and reimbursement rights are fully determined and that Group Health has an equitable lien over such monies to the full extent of Group Health's Medical Expenses and/or the Injured Person agrees to serve as constructive trustee over the monies to the extent of Group Health's Medical Expenses. In the event that such monies are not so held, the funds are recoverable even if they have been comingled with other assets, without the need to trace the source of the funds. Any party who distributes funds without regard to Group Health's rights of subrogation or reimbursement will be personally liable to Group Health for the amounts so distributed.

If reasonable collections costs have been incurred by an attorney for the Injured Person in connection with obtaining recovery, Group Health will reduce the amount of reimbursement to Group Health by the amount of an equitable apportionment of such collection costs between Group Health and the Injured Person. This reduction will be made only if each of the following conditions has been met: (i) Group Health receives a list of the fees and associated costs before settlement and (ii) the Injured Person's attorney's actions were directly related to securing recovery for the Injured Party.

Implementation of this section shall be deemed a part of claims administration and Group Health shall therefore have discretion to interpret its terms.

XII. Definitions

Agreement	The Individual and Family medical coverage Agreement between Group Health and the Contract Holder.
Allowance	The maximum amount payable by Group Health for certain Covered Services.
Allowed Amount	A term used to define the level of benefits which are payable by Group Health when expenses are incurred from a non-Network Provider. Expenses are considered an Allowed Amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between a non-Network Provider's charge for services and the Allowed Amount.
Contract Holder	The primary individual in whose name the Agreement is issued.
Convalescent Care	Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication.
Copayment	The specific dollar amount a Member is required to pay at the time of service for certain Covered Services.
Cost Share	The portion of the cost of Covered Services for which the Member is liable. Cost Share includes Copayments, coinsurances and Deductibles.

Covered Services	The services for which a Member is entitled to coverage in the Agreement.
Creditable Coverage	Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial determination measures whether the expected amount of paid claims under Group Health's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.
Deductible	A specific amount a Member is required to pay for certain Covered Services before benefits are payable.
Dependent	Any member of a Contract Holder's family who meets all applicable eligibility requirements, is enrolled hereunder and for whom the premium has been paid.
Emergency	The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent lay person acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily function or serious dysfunction of a bodily organ or part, or would place the Member's health, or if the Member is pregnant, the health of her unborn child, in serious jeopardy, or any other situations which would be considered an emergency under applicable federal or state law.
Essential Health Benefits	Benefits set forth under the Patient Protection and Affordable Care Act of 2010, including the categories of ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.
Family Unit	A Contract Holder and all his/her Dependents.
Group Health-designated Specialist	A specialist specifically identified by Group Health.
Hospital Care	Those Medically Necessary services generally provided by acute general hospitals for admitted patients.
Medical Condition	A disease, illness or injury.
Medically Necessary	Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made. Appropriate and clinically necessary services, as determined by Group Health's medical director according to generally accepted principles of good medical practice, which are rendered to a Member for the diagnosis, care or treatment of a Medical Condition and which meet the standards set forth below. In order to be Medically Necessary, services and supplies must meet the following requirements: (a) are not solely for the convenience of the Member, his/her family or the provider of the services or supplies, including exercise equipment and home modifications such as ramps and walkways; (b) are the most appropriate level of service or supply which can be safely provided to the Member; (c) are for the diagnosis or treatment of an actual or existing Medical Condition unless being provided under Group Health's schedule for preventive services; (d) are not for recreational, life-

	enhancing, relaxation or palliative therapy, except for treatment of terminal conditions; (e) are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the Member's condition or the quality of health services rendered; (f) as to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the Member's condition or quality of health services rendered; (g) are not primarily for research and data accumulation; and (h) are not experimental or investigational. The length and type of the treatment program and the frequency and modality of visits covered shall be determined by Group Health's medical director. In addition to being medically necessary, to be covered, services and supplies must be otherwise included as a Covered Service and not excluded from coverage.
Medicare	The federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
Medicare Advantage Plan	A plan of coverage for persons enrolled in Medicare Part A (hospital insurance) and Part B (medical insurance).
Member	Any enrolled Contract Holder or Dependent.
Network Facility	A facility (hospital, medical center or health care center) owned, operated or otherwise designated by Group Health, or with whom Group Health has contracted to provide health care services to Members.
Network Personal Physician	A provider who is employed by or contracted with Group Health to provide primary care services to Members and is selected by each Member to provide or arrange for the provision of all non-emergent Covered Services, except for services set forth in the Agreement which a Member can access without Preauthorization. Network Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.
Network Provider	The medical staff, clinic associate staff and allied health professionals employed by Group Health, and any other health care professional or provider with whom Group Health has contracted to provide health care services to Members, including, but not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.
Out-of-pocket Expenses	Those Cost Shares paid by the Contract Holder or Member for Covered Services which are applied to the Out-of-pocket Limit.
Out-of-pocket Limit	The maximum amount of Out-of-pocket Expenses incurred and paid during the calendar year for Covered Services received by the Contract Holder and his/her Dependents within the same calendar year. The Out-of-pocket Expenses which apply toward the Out-of-pocket Limit are set forth in Section IV.
Plan Coinsurance	The percentage amount the Member is required to pay for Covered Services received.
Preauthorization	An approval by Group Health that entitles a Member to receive Covered Services from a specified health care provider. Services shall not exceed the limits of the Preauthorization and are subject to all terms and conditions of the Agreement. Members

	who have a complex or serious medical or psychiatric condition may receive a standing Preauthorization for specialty care provider services.
Residential Treatment	A term used to define facility-based treatment, which includes 24 hours per day, 7 days per week rehabilitation. Residential Treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment centers provide active treatment of patients in a controlled environment requiring at least weekly physician visits and offering treatment by a multi-disciplinary team of licensed professionals.
Service Area	Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima.
Urgent Condition	The sudden, unexpected onset of a Medical Condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

Group Health Nondiscrimination Notice and Language Access Services

GROUP HEALTH NONDISCRIMINATION NOTICE

Group Health Cooperative and Group Health Options, Inc. ("Group Health") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Group Health Civil Rights Coordinator.

If you believe that Group Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Group Health Civil Rights Coordinator, Group Health Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@ghc.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Group Health Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어**(Korean):** 주의： 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)៖ ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-901-4636 (TTY: 1-800-833-6388 / 711) تماس بگیرید.