GroupHealth®

Group Medical Coverage Agreement

Group Health Options, Inc. (also referred to as "GHO") is a Health Care Service Contractor, duly registered under the laws of the State of Washington, furnishing health care coverage on a prepayment basis. The Group identified below wishes to purchase such coverage for its participating members (hereinafter referred to as "Participating Party"). Participating Party shall mean a group or individual which meets eligibility requirements established by the Group and agreed to by GHO for participation in the Group and in this health plan offering through the Group.

This Agreement sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties; requirements for enrollment and eligibility; and benefits to which those enrolled under this Agreement are entitled.

The Agreement between GHO and the Group consists of the following:

- Standard Provisions
- Attached Benefit Booklet(s)
- Group application
- Premium Schedule

Group Health Options, Inc.

Hanford Employee Welfare Trust (HEWT)-HAMTC & HGU Represented, #6813500/6227600

This Agreement will continue in effect until terminated or renewed as herein provided for and is effective January 1, 2010.

CA-1890T
2149EID2010

Group Medical Coverage Agreement
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Standard Provisions

Attachment 1 Benefit Booklet

Attachment 2 Premium Schedule

Standard Provisions

1. **Administration of Agreement.** GHO 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.

2. **Modification of Agreement.** Except as required by federal and Washington State law, this Agreement may not be modified without agreement between both parties.

   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.

3. **Indemnification.** GHO agrees to indemnify and hold the Group, including Participating Parties, harmless against all claims, damages, losses and expenses, including reasonable attorney's fees, arising out of GHO's failure to perform, negligent performance or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

   The Group, including Participating Parties, agrees to indemnify and hold GHO harmless against all claims, damages, losses, and expenses, including reasonable attorney's fees, arising out of the Group's or Participating Party's failure to perform, negligent performances or willful misconduct of its directors, officers, employees and agents of their express obligations under this Agreement.

   The indemnifying party shall give the other party prompt notice of any claim covered by this section and provide reasonable assistance (at its expense). The indemnifying party shall have the right and duty to assume the control of the defense thereof with counsel reasonably acceptable to the other party. Either party may take part in the defense at its own expense after the other party assumes the control thereof.

4. **Arbitration.** Any dispute, controversy or difference between GHO and the Group, including Participating Parties, arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration in Seattle, Washington in accordance with the Commercial Arbitration Rules of the American Arbitration Association, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Except as may be required by law, neither party nor arbitrator may disclose the existence, content or results of any arbitration hereunder without the prior written consent of both parties.

5. **HIPAA.**

   Definition of Terms. Terms used, but not otherwise defined, in this Section shall have the same meaning as those terms have in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

   Transactions Accepted. GHO will accept Standard Transactions, pursuant to HIPAA, if the Group elects to transmit such transactions. If the Group sends transactions to GHO that do not comply with applicable HIPAA standards, the Group will be deemed by such action to be representing and warranting that it is not a Covered Entity or otherwise required to comply with HIPAA standards for electronic transactions, either directly, or as an agent of another individual or entity. The parties agree that all the terms, conditions, representations and warranties contained in this section are express obligations of the Group, and the Group shall indemnify GHO for any breach of this section.

6. **Termination of Entire Agreement.** This is a guaranteed renewable Agreement and cannot be terminated without the mutual approval of each of the parties, except in the circumstances set forth below.

   a. **Nonpayment or Non-Acceptance of Premium.** Failure to make any monthly premium payment or contribution in accordance with subsection 9.a.i. below shall result in termination of this Agreement as of the premium due date. The Group's failure to accept the revised premiums provided as part of the annual renewal process shall be considered nonpayment and result in non-renewal of this Agreement. The Group

may terminate this Agreement upon fifteen (15) days written notice of premium increase, as set forth in subsection 9.a.i. below.

b. Misrepresentation. GHO may rescind or terminate this Agreement upon written notice in the event that intentional misrepresentation, fraud or omission of information was used in order to obtain Group coverage. Either party may terminate this Agreement in the event of intentional misrepresentation, fraud or omission of information by the other party in performance of its responsibilities under this Agreement.

c. Underwriting Guidelines. GHO may terminate this Agreement in the event the Group no longer meets underwriting guidelines established by GHO that were in effect at the time the Group was accepted.

Participation rules as established by the Group and agreed to by GHO are incorporated into this Agreement. Any changes to those requirements by the Group will be deemed to constitute a termination of the current Agreement by the Group. GHO will have the right to determine whether or not it wishes to enter into a new Agreement that includes the new participation requirements.

d. Federal or State Law. GHO may terminate this Agreement in the event there is a change in federal or state law that no longer permits the continued offering of the coverage described in this Agreement.

7. Withdrawal or Cessation of Services.

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

b. GHO may determine to cease to offer the Group's current 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. GHO may also allow unrestricted conversion to a fully comparable GHO product.

GHO will provide written notice to each covered Member of the discontinuation or non-renewal of the plan at least ninety (90) days prior to discontinuation.

8. Termination of Participating Parties.

a. Failure to meet Eligibility Requirements. GHO may terminate a Participating Party's coverage under this Agreement if such party no longer meets the requirements established by the Group and approved by GHO for participation in the Group medical plan.

b. Nonpayment or Non-Acceptance of Premium. Failure to make any monthly premium payment or contribution in accordance with subsection 6.a. shall result in termination as of the premium due date. The Participating Party's failure to accept the revised premiums provided as part of the annual renewal process shall be considered nonpayment and result in non-renewal of the Participating Party's coverage under this Agreement.

9. Responsibilities of Parties.

a. Group's Responsibilities.

i. Monthly Premium Payments. For the initial term of this Agreement, the Group shall submit to GHO for each Participating Party the monthly premiums set forth in the current Premium Schedule and a verification of enrollment. Payment must be received on or before the due date, and is subject to a grace period of ten (10) days. Premiums are subject to change by GHO upon thirty (30) days written notice. Premium rates will be revised as a part of the annual renewal process.

Except for services for hospitalization as set forth in Section III.C., the Group will be responsible for costs of any claims incurred or services provided after retroactive termination of this Agreement or retroactive termination of a Participating Party in the Group because of non-payment of premium.

The Group will be responsible for the cost of any claims incurred for services paid or provided in reliance on inaccurate reporting of member enrollment made by the Group.

In the event the Group increases or decreases enrollment at least twenty-five percent (25%) or more, GHO reserves the right to require re-rating of the Group.

If agreed to in advance, responsibility under this Monthly Premium Payments provision may be assigned to each Participating Party. Such assignment will be noted in the Group Master Application attached to and incorporated into this Agreement.

ii. Enrollment Verification and Reporting Requirements. The Group will verify enrollment of all Members of Participating Parties eligible for enrollment under this Agreement, and ensure that appropriate documentation is submitted to GHO for approval.

If agreed to in advance, responsibility under this Enrollment Verification and Reporting Requirements provision may be assigned to each Participating Party. Such assignment will be noted in the Group Master Application attached to and incorporated into this Agreement.

iii. Establishment and Enforcement of Participation Requirements. The Group will establish and maintain rules regarding participation in the Group, and ensure consistent application of those rules. The Group will notify Participating Parties and GHO when the Participating Party no longer qualifies under the criteria for participation established by the Group.

The Group will be responsible for the cost of any claims incurred for services paid or provided to non-qualified parties as a result of the Group failure to enforce participation requirements.

b. GHO's Responsibilities.

i. Provision of Benefits. GHO agrees to provide benefits as set forth in the attached Benefit Booklet to enrollees of the Group.

ii. Dissemination of Information. Unless the Group has accepted responsibility to do so, GHO will disseminate information describing benefits set forth in the Benefit Booklet attached to this Agreement.

iii. Identification Cards. GHO will furnish cards, for identification purposes only, to all Members enrolled under this Agreement.

iv. Governmental Approval. If GHO has not received any necessary government approval by the date when notice is required under this Agreement, GHO will notify the Group of any changes once governmental approval has been received. GHO may amend this Agreement by giving notice to the Group 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 Group unless the Group gives GHO written notice of non-acceptance within thirty (30) days after receipt of amendment, in which event this Agreement and all rights to services and other benefits terminate the first of the month following thirty (30) days after receipt of non-acceptance.

c. Joint Responsibilities.

i. Compliance With Law. The Group and GHO 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 ERISA and other federal laws.

ii. Confidentiality. Each party acknowledges that performance of its obligations under this Agreement may involve access to and disclosure of data, procedures, materials, lists, systems and information, including medical records, employee benefits information, employee addresses, social security numbers, e-mail addresses, phone numbers and other confidential information regarding the Group's employees (collectively the "information"). The information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and employee information as required by applicable law.

Dear Group Health Options Subscriber:

This booklet contains important information about your healthcare plan.

This is your 2010 GHO Benefit Booklet (Certificate of Coverage). It explains the services and benefits you and those enrolled on your contract are entitled to receive from Group Health Options, Inc. Sections of this document may be ***bolded and italicized,*** which identifies changes that Group Health has made to the plan. The benefits reflected in this booklet were approved by your employer or association who contracts with Group Health Options, Inc., for your healthcare coverage. If you are eligible for Medicare, please read Section IV.J. as it may affect your prescription drug coverage.

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

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

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

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

Very truly yours,

Scott Armstrong
President

CA-1890a, CA-3620, CA-2362,CA-2316ad,CA-2249,CA-2022,CA-2272,CA-2287,CA-3574,CA-1880,CA-1892,CA-2301,CA-2245,CA-2100,CA-3423
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Section I. Introduction

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

Read This Benefit Booklet Carefully

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

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

A. Accessing Care

Members are entitled to Covered Services from either:

- GHO's Managed Health Care Network, referred to as "MHCN," or
- Community Providers or Preferred Community Providers on a Self-Referred basis.

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

Benefits paid under one option will not be duplicated under the other option.

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

- Emergency care,
- Self-Referral to women's MHCN health care providers, as set forth below,
- Visits with MHCN-Designated Self-Referral Specialists, as set forth below,
- Care provided pursuant to a Referral. Referrals must be requested by the Member's MHCN Personal Physician and approved by GHO, and
- Other services as specifically set forth in the Allowances Schedule and Section IV.

Some services are covered only when obtained from or upon Referral by the MHCN.

All inpatient admissions prescribed by a Community Provider must be authorized in advance by GHO. Members may refer to Sections IV.A. ***and IV.C***. for more information about inpatient admissions.

Primary Care. ***GHO recommends that*** Members select a MHCN Personal Physician when enrolling under the Agreement. One Personal Physician may be selected for an entire family, or a different Personal Physician may be selected for each family member.

Selecting a Personal Physician or changing from one Personal Physician to another can be accomplished by contacting GHO Customer Service, or accessing the GHO website at www.ghc.org. The change will be made within twenty-four (24) hours of the receipt of the request, if the selected physician's caseload permits.

A listing of MHCN Personal Physicians, Referral specialists, women's health care providers and MHCN-Designated Self-Referral Specialists is available by contacting GHO Customer Service at (206) 901-4636 or (888) 901-4636, or by accessing GHO's website at www.ghc.org.

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

Specialty Care. Unless otherwise indicated in this section, the Allowances Schedule or Section IV., Referrals are required for specialty care and specialists inside the network.

MHCN-Designated Self-Referral Specialist. Members may make appointments directly with MHCN-Designated Self-Referral Specialists at Group Health-owned or -operated medical centers without a Referral from their Personal Physician. Self-Referrals are available for the following specialty care areas: allergy, audiology, cardiology, chemical dependency, chiropractic/manipulative therapy, 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.

* Medicare patients need prior authorization for these specialists.

Women's Health Care Direct Access Providers. Female Members may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Licensed Midwife, Doctor of Osteopathy, Pediatrician, Obstetrician or Advanced Registered Nurse Practitioner who is contracted by GHO to provide women's health care services directly, without a Referral from their Personal Physician, for Medically Necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for the above services. Within the MHCN, women's health care services are covered as if the Member's Personal Physician had been consulted, subject to any applicable Cost Shares, as set forth in the Allowances Schedule. Women's health care services obtained from a Community Provider are covered at the Community Provider benefit level. If the Member's women's health care provider diagnoses a condition that requires Referral to other specialists or hospitalization, the Member or her chosen provider must obtain preauthorization and care coordination in accordance with applicable GHO requirements.

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

Emergent and Urgent Care. Emergent care is available at MHCN Facilities. If Members cannot get to a MHCN Facility, Members may obtain Emergency services from the nearest hospital. Members, or persons assuming responsibility for a Member must notify GHO by way of the GHO Emergency Notification Line within twenty-four (24) hours of any admission, or as soon thereafter as medically possible. Members may refer to Section IV. for more information about coverage of Emergency services under the MHCN and Community Provider options.

Under the MHCN option, urgent care is covered at MHCN medical centers, MHCN urgent care clinics or MHCN Provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN Provider. Members may refer to Section IV. for more information about coverage of urgent care services.

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

Recommended Treatment. Under the MHCN option, GHO's Medical Director, or his/her designee will determine the necessity, nature and extent of treatment to be covered under the MHCN benefit in each individual case and the judgment, made in good faith, will be final.

Members have the right to participate in decisions regarding their health care. A Member may refuse any recommended treatment or diagnostic plan to the extent permitted by law. Members who obtain care not recommended by GHO, do so with the full understanding that such care will not be covered at the MHCN benefit level. Coverage decisions may be appealed as set forth in Section VI.

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

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

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

B. Cost Shares

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

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

2. **Annual Deductible.**

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

      Charges subject to the annual Deductible shall be borne by the Subscriber during each year until the annual Deductible is met. In order for charges to be applied to the annual Deductible, Covered Services must be obtained at MHCN Facilities, unless the Member has received a Referral from a MHCN Provider which has been approved by GHO or has received Emergency services according to the Schedule of Benefits, Section IV.L.

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

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

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

3. **Individual Annual Deductible Carryover.** Under either option, charges applied toward the individual annual Deductible during the months of October, November and December are also applied in an equal

amount toward the Member's annual Deductible for the next calendar year. The individual annual Deductible carryover will apply only when expenses incurred have been paid in full. The aggregate Family Unit Deductible does not carry over into the next calendar year.

4. **Coinsurance.**

   a. **MHCN.** After the annual Deductible is satisfied, Members shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

   b. **Community Provider.** After the annual Deductible is satisfied, Members shall be required to pay the Plan Coinsurance for Covered Services as set forth in the Allowances Schedule.

   A benefit-specific coinsurance may apply to some Covered Services, as set forth in the Allowances Schedule. Services that are subject to the benefit-specific coinsurance are not subject to the Plan Coinsurance.

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

C. Subscriber's Liability

The Subscriber is liable for (1) payment to the Group of his/her contribution toward the monthly premium, if any; (2) payment of Cost Share amounts for Covered Services provided to the Subscriber and his/her Dependents, as set forth in the Allowances Schedule; and (3) payment of any fees charged for non-Covered Services provided to the Subscriber and his/her Dependents, at the time of service.

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

D. Claims

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

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

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

- Pre-service claims – within fifteen (15) days.
- Claims involving urgently needed care – within seventy-two (72) hours.
- Concurrent care claims – within twenty-four (24) hours.
- Post-service claims – within thirty (30) days.

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

Section II. Allowances Schedule

MHCN:	**Describes coverage when care is provided by a MHCN Provider or referred by a MHCN Personal Physician. Benefits paid under the MHCN option will not be duplicated under the Community Provider option.**
Community Provider:	**Describes coverage when care is provided by a Community Provider or Preferred Community Provider on a Self-Referred basis. Coverage is limited to the Preferred Community Provider Contracted Rate or Usual, Customary and Reasonable (UCR) charges, less any applicable Cost Share amounts as noted below. Benefits paid under the Community Provider option will not be duplicated under the MHCN option.**

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

"Welcome" Outpatient Services Waiver

Not applicable.

Annual Deductible

MHCN: $100 per Member or $200 per Family Unit per calendar year.

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

Plan Coinsurance

MHCN: Plan Coinsurance share is 80%; Member coinsurance share is 20%, after the annual Deductible is satisfied.

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

Lifetime Maximum

$2,000,000 per Member for Covered Services incurred, unless otherwise indicated. Up to $5,000 is restored automatically each January 1 for benefits paid by GHO during the prior calendar year.

Hospital Services

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

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

  Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Preauthorization is required for scheduled admissions as set forth in Section IV.A.

- Covered outpatient hospital surgery (including ambulatory surgical centers)

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

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

Outpatient Services

- Covered outpatient medical and surgical services

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

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

- Allergy testing

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

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

- Oncology (radiation therapy, chemotherapy)

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

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

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

- Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHO drug formulary

  MHCN: Covered when prescribed by a MHCN Provider, subject to the lesser of the MHCN's charge or a $15 Copayment for generic drugs or a $30 Copayment for brand name drugs.

  Community Provider: Covered subject to the lesser of the allowed charge or a $20 Copayment for generic drugs or a $35 Copayment for brand name drugs.

- Over-the-counter drugs and medicines

  Not covered.

- Allergy serum

  MHCN: Covered in full.

  Community Provider: Covered subject to the lesser of the allowed charge or the applicable prescription drug Cost Share for each thirty (30) day supply.

- Injectables

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

Community Provider: Injections that can be self-administered are subject to the lesser of the allowed charge or the applicable prescription drug Cost Share (as set forth above). Injections necessary for travel are not covered.

- Mail order drugs and medicines

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

  Community Provider: Not covered.

Out-of-Pocket Limit

MHCN: Limited to an aggregate maximum of $1,000 per Member or $2,000 per family per calendar year. Except as otherwise noted in this Allowances Schedule, the total Out-of-Pocket Expenses for the following Covered Services are included in the Out-of-Pocket Limit:

- Annual Deductible
- Plan Coinsurance
- Emergency care at a MHCN Facility
- Ambulance services

Community Provider: Limited to an aggregate maximum of $2,875 per Member or $5,750 per family per calendar year. Except as otherwise noted in this Allowances Schedule, the total Out-of-Pocket Expenses for the following Covered Services are included in the Out-of-Pocket Limit:

- Annual Deductible
- Plan Coinsurance
- Emergency care at a non-MHCN Facility

Acupuncture

MHCN: Covered subject to the lesser of the MHCN's charge or the applicable outpatient services Copayment and at the Plan Coinsurance for Self-Referrals to a MHCN Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year, after the annual Deductible is satisfied. When approved by GHO, additional visits are covered.

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

Ambulance Services

- Emergency ground/air transport

  MHCN: Covered at 80% for transport to a MHCN Facility. Not subject to the annual Deductible.

  Community Provider: Covered at 80% for transport to a non-MHCN Facility. Not subject to the annual Deductible.

- Non-emergent ground/air interfacility transfer

  MHCN: Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full. Not subject to the annual Deductible.

Community Provider: Covered at 80% for transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment when prescribed by the attending physician. Not subject to the annual Deductible.

Chemical Dependency

- Inpatient services ***(including Residential Treatment services)***

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

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

- Outpatient services

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

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

Acute detoxification covered as any other medical service.

Dental Services (including accidental injury to natural teeth)

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

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

Devices, Equipment and Supplies (for home use)

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

  MHCN: Covered at 80%.

  Community Provider: Covered at 80% after the annual Deductible is satisfied.

- Ostomy supplies
- Prosthetic devices

  MHCN: Covered at 80%.

  Community Provider: Covered at 80% after the annual Deductible is satisfied.

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

Diabetic Supplies

MHCN: Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies - see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered in full. When Devices, Equipment and Supplies or Drugs-Outpatient are covered and have benefit limits, diabetic supplies are not subject to these limits.

Community Provider: Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors and supplies - see Devices, Equipment and Supplies. Blood glucose monitoring reagents and urine testing reagents are covered at the Plan Coinsurance after the annual Deductible is satisfied. When Devices, Equipment and Supplies or Drugs-Outpatient are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic Laboratory and Radiology Services

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

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

Emergency Services

MHCN: Covered subject to the lesser of the MHCN's charge or a $75 Copayment per Member per Emergency visit at a MHCN Facility and at the Plan Coinsurance after the annual Deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Community Provider: Covered subject to a $125 Copayment or total charge of services, whichever is less, at a non-MHCN Facility and at the MHCN Plan Coinsurance after the MHCN annual Deductible is satisfied. Emergency admissions are covered subject to the applicable inpatient services Cost Share.

Copayment is waived if the Member is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the Member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services the Member receives are covered subject to the applicable inpatient services Cost Share.

Hearing Examinations and Hearing Aids

- Hearing examinations to determine hearing loss

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

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

- Hearing aids, including hearing aid examinations

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

  MHCN: Covered up to a $400 maximum per ear limited to one (1) aid per ear during a period of three (3) consecutive years.

  Community Provider: Covered up to a $400 maximum per ear limited to one (1) aid per ear during a period of three (3) consecutive years.

Home Health Services

MHCN: Covered in full. No visit limit.

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

Hospice Services

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

Community Provider: Covered at the Plan Coinsurance after the annual Deductible is satisfied. Inpatient respite care is covered for a maximum of five (5) consecutive days per occurrence. Preauthorization is required for scheduled hospice admissions, as set forth in Section IV.A.

Infertility Services (including sterility)

- General diagnostic services

  MHCN: Covered subject to the lesser of the MHCN's charge or the applicable outpatient services Cost Share.

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

- Specific diagnostic services, treatment and outpatient prescription drugs

  MHCN: Covered at 50% (Member's Cost Share will not exceed the MHCN's charge).

  Community Provider: Covered at 50% after the annual Deductible is satisfied (Member's Cost Share will not exceed the allowed charge). Outpatient prescription drugs are not subject to the annual Deductible.

Manipulative Therapy

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

MHCN: Covered subject to the lesser of the MHCN's charge or the applicable outpatient services Copayment and at the Plan Coinsurance for Self-Referrals to a MHCN Provider for manipulative therapy of the spine and extremities in accordance with GHO clinical criteria up to a maximum of twenty (20) visits per Member per calendar year after the annual Deductible is satisfied.

Community Provider: Covered subject to the lesser of the allowed charge or the applicable outpatient services Copayment and at the Plan Coinsurance for manipulative therapy of the spine or extremities up to a maximum of twenty (20) visits per Member per calendar year, after the annual Deductible is satisfied.

Maternity and Pregnancy Services

- Delivery and associated Hospital Care

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

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

- Prenatal and postpartum care

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

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

- Pregnancy termination

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

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

Mental Health Services

- Inpatient services

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

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

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

- Outpatient services

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

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

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

Naturopathy

MHCN: Covered subject to the lesser of the MHCN's charge or the applicable outpatient services Copayment and at the Plan Coinsurance for Self-Referrals to a MHCN Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, after the annual Deductible is satisfied. When approved by GHO, additional visits are covered.

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

Nutritional Services

- Phenylketonuria (PKU) supplements

  MHCN: Covered in full.

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

- Enteral therapy (formula)

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

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

- Parenteral therapy (total parenteral nutrition)

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

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

Obesity Related Services

MHCN: Covered ***subject to the lesser of the MHCN's charge or the applicable Cost Share*** for bariatric surgery. Weight loss programs, medications and related physician visits for medication monitoring are not covered.

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

On the Job Injuries or Illnesses

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

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

Optical Services

- Routine eye examinations

  MHCN: Covered in full once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the applicable outpatient services Copayment and at the Plan Coinsurance as often as Medically Necessary.

  Community Provider: Covered up to $50 of Usual, Customary and Reasonable charges once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the applicable outpatient services Copayment and at the Plan Coinsurance as often as Medically Necessary, after the annual Deductible is satisfied.

- Lenses, including contact lenses, and frames

Eyeglass frames, lenses (any type), lens options such as tinting, or prescription contact lenses, contact lens evaluations and examinations associated with their fitting - Covered up to $165 per twenty-four (24) month period per Member. The benefit period begins on the date services are first obtained and continues for twenty-four (24) months. Lenses and frames are not subject to the annual Deductible or Plan Coinsurance.

- Contact lenses for eye pathology, including following cataract surgery

  MHCN: Covered in full.

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

Organ Transplants

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

MHCN: Covered subject to the lesser of the MHCN's charge or the applicable Cost Share up to a $350,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to $50,000).

Community Provider: Covered subject to the lesser of the allowed charge or the applicable Cost Share up to a $350,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to $50,000).

Plastic and Reconstructive Services (plastic surgery, cosmetic surgery)

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

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

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

- Cosmetic surgery, including complications resulting from cosmetic surgery

  MHCN: Not covered.

  Community Provider: Not covered.

Podiatric Services

- Medically Necessary foot care

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

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

- Foot care (routine)

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

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

Pre-Existing Condition

Covered with no wait.

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

MHCN: Covered in full when in accordance with the well care schedule established by GHO. Not subject to the annual Deductible or any applicable Plan Coinsurance. Eye refractions are not included under preventive care. Physicals for travel, employment, insurance or license are not covered. Services provided during a preventive care visit which are not in accordance with the well care schedule are covered subject to the lesser of the MHCN's charge or any applicable outpatient services Cost Share.

Community Provider: Covered at the Plan Coinsurance to a $150 maximum per Member ($300 per Family Unit) per calendar year. Routine mammography services are covered at the Plan Coinsurance after the annual Deductible is satisfied. Coinsurance does not apply to the Out-of-Pocket Limit.

Rehabilitation Services

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

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

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

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

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

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

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

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

Sexual Dysfunction Services

MHCN: Not covered.

Community Provider: Not covered.

Skilled Nursing Facility (SNF)

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

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

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

Sterilization (vasectomy, tubal ligation)

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

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

Temporomandibular Joint (TMJ) Services

- Inpatient and outpatient TMJ services

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

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

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

- Lifetime benefit maximum

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

  MHCN: Covered up to $5,000 per Member.

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

Tobacco Cessation

- Individual/group sessions

  MHCN: Covered in full.

  Community Provider: Not covered.

- Approved pharmacy products

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

  Community Provider: Not covered.

Section III. Eligibility, Enrollment and Termination

A. Eligibility

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

1. **Subscribers.** Bona fide employees who have been continuously employed on a regularly scheduled basis of not less than twenty (20) hours per week shall be eligible for enrollment.

2. **Dependents.** The Subscriber may also enroll the following:

   a. The Subscriber's legal spouse***, including state-registered domestic partners as required by Washington state law***;

   b. Unmarried dependent children who are under the age of twenty-five (25). Coverage for Dependents cannot be added or reinstated after age twenty-five (25).

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

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

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

B. Enrollment

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

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

   a. Newly Eligible Persons. Newly eligible Subscribers and their Dependents may apply for enrollment in writing to the Group within thirty-one (31) days of becoming eligible.

   b. New Dependents. A written application for enrollment of a newly dependent person, other than a newborn or adopted child, must be made to the Group within thirty-one (31) days after the dependency occurs.

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

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

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

c. Open Enrollment. GHO will allow enrollment of Subscribers and Dependents, who did not enroll when newly eligible as described above, during a limited period of time specified by the Group and GHO.

d. Special Enrollment.

1) GHO will allow special enrollment for persons:
   a) who initially declined enrollment when otherwise eligible because such persons had other health care coverage and have had such other coverage terminated due to one of the following events:
      - cessation of employer contributions,
      - exhaustion of COBRA continuation coverage,
      - loss of eligibility, except for loss of eligibility for cause; or
   b) who have had such other coverage exhausted because such person reached a Lifetime Maximum limit.

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

2) GHO will allow special enrollment for ***individuals who are*** eligible to be a Subscriber, his/her spouse and ***his/her Dependents*** in the event one of the following occurs:
   - marriage. Application for coverage under the Agreement must be made within thirty-one (31) days of the date of marriage.
   - birth. Application for coverage under the Agreement ***for the Subscriber and Dependents other than the newborn child*** must be made within sixty (60) days of the date of birth.
   - adoption or placement for adoption. Application for coverage under the Agreement ***for the Subscriber and Dependents other than the adopted child*** must be made within sixty (60) days of the adoption or placement for adoption.
   - eligibility for medical assistance: provided such person is otherwise eligible for coverage under this Agreement, when approved and requested in advance by the Department of Social and Health Services (DSHS).
   - ***applicable federal or state law or regulation otherwise provides for special enrollment.***

2. Limitation on Enrollment. The Agreement will be open for applications for enrollment as set forth in this Section III.B. Subject to prior approval by the Washington State Office of the Insurance Commissioner, GHO may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that GHO's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

C. Effective Date of Enrollment

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

   - Enrollment for a newly eligible Subscriber and listed Dependents is effective on the date of hire provided the Subscriber's application has been submitted to and approved by GHO.

- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the date of eligibility.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption and the Subscriber assumes total or partial financial support of the child.

2. **Commencement of Benefits for Persons Hospitalized on Effective Date.** Members who are admitted to an inpatient facility prior to their enrollment under the Agreement, and who do not have coverage under another agreement, will receive covered benefits beginning on their effective date, as set forth in subsection C.1. above. If a Member is hospitalized in a non-MHCN Facility, GHO reserves the right to require transfer of the Member to a MHCN Facility. The Member will be transferred when a MHCN 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 MHCN Facility, all services received will be covered under the Community Provider option of the Inpatient Hospital Services section set forth in the Allowances Schedule.

D. Eligibility for Medicare

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), actively employed Members and their spouses who are eligible for Medicare benefits must decide whether to choose the benefits of the Agreement or the Medicare program as their primary source of health care coverage. The Group is responsible for providing the Member with necessary information regarding TEFRA eligibility and the selection process.

For purposes of this section, an individual shall be deemed eligible for Medicare when he/she has the option to receive Part A Medicare benefits.

Except as otherwise required by TEFRA, GHO will only provide benefits for Covered Services, subject to the Coordination of Benefits provision under the Agreement as set forth in Section VII.

E. Termination of Coverage

1. **Termination of Specific Members.** Individual Member coverage may be terminated for any of the following reasons:

   a. **Loss of Eligibility.** If a Member no longer meets the eligibility requirements set forth in Section III., and is not enrolled for continuation coverage as described in Section III.G. below, coverage under the Agreement will terminate at midnight on the date of termination, unless otherwise specified by the Group.

   b. **For Cause.** Coverage of a Member may be terminated upon ten (10) working days written notice for:
      i. Material misrepresentation, fraud or omission of information in order to obtain coverage.
      ii. Permitting the use of a GHO identification card or number by another person, or using another Member's identification card or number to obtain care to which a person is not entitled.

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

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

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

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

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

F. Services After Termination of Agreement

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

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

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

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

G. Continuation of Coverage Options

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

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

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

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

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

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

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

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

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

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

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

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

Section IV. Schedule of Benefits

Benefits are subject to all provisions of the Group Medical Coverage Agreement, including, without limitation, the Accessing Care provisions and General Exclusions. Members must refer to Section II., the Allowances Schedule, for Cost Shares and specific benefit limits that apply to benefits listed in this Schedule of Benefits. Members are entitled to receive only benefits and services that are Medically Necessary and clinically appropriate for the treatment of a Medical Condition as determined by GHO's Medical Director, or his/her designee, and as described herein. All Covered Services are subject to case management and utilization review at the discretion of GHO.

A. Hospital Care

The following hospital services are covered, (1) under the MHCN option when provided or referred by the MHCN, or (2) under the Community Provider option when authorized in advance by GHO:

1. Room and board, including private room when prescribed, and general nursing services.

2. Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).

3. Alternative care arrangements may be covered as a cost-effective alternative in lieu of otherwise covered Medically Necessary hospitalization, or other covered Medically Necessary institutional care. Alternative care arrangements in lieu of covered hospital or other institutional care must be determined to be appropriate and Medically Necessary based upon the Member's Medical Condition. Coverage must be authorized in advance by GHO as appropriate and Medically Necessary. Such care will be covered to the same extent the replaced Hospital Care is covered under the Agreement.

4. Drugs and medications administered during confinement.

5. Special duty nursing, when prescribed as Medically Necessary.

Except as specifically provided below, all inpatient admissions prescribed by a Community Provider must be authorized by GHO at least seventy-two (72) hours in advance.

Members receiving the following nonscheduled services are required to notify GHO by way of the GHO Notification Line within twenty-four (24) hours following a nonscheduled admission, or as soon thereafter as medically possible: labor and delivery, Emergency care services, and inpatient admissions needed for treatment of Urgent Conditions that cannot reasonably be delayed until preauthorization can be obtained.

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

B. Medical and Surgical Care

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

1. Surgical services.

2. Diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. ***Under the Community Provider option, high end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.***

3. Family planning counseling services.

4. Hearing examinations to determine hearing loss.

   Hearing aid examinations, hearing aids and fittings when authorized by a physician.

   Excluded:

   a. Replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the Member is eligible under the limitation set forth in the Allowances Schedule.
   b. Replacement parts, replacement batteries and maintenance costs.

5. Blood and blood derivatives and their administration.

6. Preventive care (well care) services for health maintenance in accordance with the well care schedule established by GHO for the following:

MHCN: Routine mammography screening, physical examinations and routine laboratory tests for cancer screening in accordance with the well care schedule established by GHO, and immunizations and vaccinations listed as covered in the GHO drug formulary (approved drug list). A fee may be charged for health education programs. The well care schedule is available in Group Health clinics, by accessing GHO's website at www.ghc.org, or upon request.

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

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

7. Radiation therapy services.

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

9. Medical implants.

   Excluded: internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by GHO's Medical Director, or his/her designee.

10. Respiratory therapy.

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

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

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

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

13. Optical services.

    MHCN: Routine eye examinations and refractions received at a MHCN Facility once every twelve (12) months, except when Medically Necessary.

    When dispensed through MHCN Facilities, one contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery performed by a MHCN Provider, provided the Member has been continuously covered by GHO since such surgery. Replacement of a covered contact lens will be covered only when needed due to a change in the Member's Medical Condition, but no more than once in a twelve (12) month period.

    Excluded: evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures, and contact lens fittings and related examinations, except as set forth above.

    Community Provider: Eye examinations for eye pathology when Medically Necessary.

One contact lens per diseased eye in lieu of an intraocular lens, including exam and fitting, is covered for Members following cataract surgery, provided the Member has been continuously covered by GHO since such surgery. Replacement of a covered contact lens will be covered only when needed due to a change in the Member's Medical Condition, but no more than once in a twelve (12) month period.

Excluded: routine eye examinations and refractions, evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures, and contact lens fittings and related examinations, except as set forth above.

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

    Prenatal testing for the detection of congenital and heritable disorders when Medically Necessary as determined by GHO's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.

    Hospitalization and delivery, including home births for low risk pregnancies. Planned home births must be authorized in advance by GHO.

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

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

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

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

    a. Inpatient and outpatient medical expenses listed below for transplantation procedures:

        - 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

        Transplantation expenses listed above are subject to the Member's organ transplant lifetime benefit maximum set forth in the Allowance Schedule from one (1) day prior to the date of the transplant (or the date of the hospital admission during which the transplant occurs) through one hundred (100) days after the transplant. Services received during a hospital admission that are not related to the transplant will not count towards the transplant lifetime benefit maximum.

        Donor-related services received at any time also apply to the organ transplant lifetime benefit maximum. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees.

    b. Follow-up services for specialty visits,

c. Rehospitalization, and
d. Maintenance medications.

Under the Community Provider option, transplant services must be authorized in advance by GHO.

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

16. Manipulative therapy.

    MHCN: Self-Referrals for manipulative therapy of the spine and extremities are covered as set forth in the Allowances Schedule when provided by MHCN Providers.

    Community Provider: Manipulative therapy is covered as set forth in the Allowances Schedule.

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

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

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

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

18. Diabetic training and education.

19. Detoxification services for alcoholism and drug abuse.

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

    Coverage for acute chemical withdrawal is provided without prior approval. If a Member is hospitalized in a non-MHCN Facility/program, coverage is subject to payment of the Emergency ***care Cost Share***. The Member or person assuming responsibility for the Member must notify GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible. Furthermore, if a Member is hospitalized in a non-MHCN Facility/program, GHO reserves the right to require transfer of the Member to a MHCN Facility/program upon consultation between a MHCN Provider and the attending physician. If the Member refuses transfer to a MHCN Facility/program, all services received will be covered under the Community Provider option.

20. Circumcision.

21. Bariatric surgery and related hospitalizations when GHO criteria are met.

    MHCN: Covered

Community Provider: Not covered.

Excluded: pre and post surgical nutritional counseling and related weight loss programs, prescribing and monitoring of drugs, structured weight loss and/or exercise programs and specialized nutritional counseling.

22. Sterilization procedures.

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

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

24. Self-Referrals to licensed acupuncturists and naturopaths for Covered Services, as set forth in the Allowances Schedule.

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

    Excluded: herbal supplements, preventive care visits to acupuncturists and any services not within the scope of their licensure.

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

26. Infertility services when authorized as medically appropriate by GHO, and in accordance with criteria established by GHO, limited to general diagnostic services, and specific diagnostic services, medical and surgical treatment and drug therapy.

    Excluded: all forms of artificial intervention, including insemination, GIFT, ZIFT, in vitro fertilization and diagnosis and treatment of sexual dysfunction.

27. Diabetic supplies when authorized by a physician for the treatment of diabetes, limited to the following supplies, provided they are listed in the GHO drug formulary:

    a. Insulin syringes
    b. Urine-testing reagents
    c. Blood-glucose monitoring reagents

    External insulin pumps, glucose monitoring equipment and lancets are covered as set forth in the Allowances Schedule.

    Under the MHCN option, all supplies must be obtained at MHCN pharmacies or listed as approved MHCN stock.

C. Chemical Dependency Treatment.

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

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

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

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

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

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

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

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

2. Correction of a Medical Condition following an injury or resulting from surgery covered by GHO which has produced a major effect on the Member's appearance, when in the opinion of GHO's Medical Director, or his/her designee, such services can reasonably be expected to correct the condition.

3. Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed.

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

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

Excluded: complications of noncovered surgical services.

E. Home Health Care Services. Home health care services, as set forth in this section, shall be covered (1) under the MHCN option, when provided by MHCN's Home Health Services or referred in advance by a MHCN Personal Physician to a MHCN-authorized home health agency, or (2) under the Community Provider option, when provided by a State-licensed home health agency, prescribed by a Community Provider and authorized in advance by GHO's Medical Director, or his/her designee.

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

1. The Member is unable to leave home due to his/her health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.

2. The Member requires intermittent skilled home health care services, as described below.

3. A MHCN Provider under the MHCN option, or GHO's Medical Director, or his/her designee, under the Community Provider option, has determined that such services are Medically Necessary and are most appropriately rendered in the Member's home.

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

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

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

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

- A physician has determined that the Member's illness is terminal and life expectancy is six (6) months or less.
- The Member has chosen a palliative treatment focus (emphasizing comfort and supportive services rather than treatment aimed at curing the Member's terminal illness).
- The Member has elected in writing to receive hospice care through a hospice program.
- The Member has available a primary care person who will be responsible for the Member's home care.
- A physician and the hospice agency have determined that the Member's illness can be appropriately managed in the home.

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

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

a. Home Services

i. Intermittent care by a hospice interdisciplinary team which may include services by a physician, nurse, medical social worker, physical therapist, speech therapist, occupational therapist, respiratory therapist, limited services by a Home Health Aide under the supervision of a Registered Nurse and homemaker services.

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

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

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

c. Other covered hospice services may include the following:

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

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

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

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

G. Rehabilitation Services.

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

a. All services must be (1) prescribed and provided by a MHCN-approved rehabilitation team at a MHCN or MHCN-approved rehabilitation facility under the MHCN option, or (2) prescribed and provided by a rehabilitation team under the Community Provider option, that may include medical, nursing, physical therapy, occupational therapy, massage therapy and speech therapy providers.

b. Under the Community Provider option, inpatient rehabilitation services must be authorized in advance by GHO.

c. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the Member's condition can be expected within a sixty (60) day period as a consequence of intervention by covered therapy services described in paragraph a., above.

d. Coverage for inpatient and outpatient services is limited to the Allowance set forth in the Allowances Schedule.

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

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

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

H. Devices, Equipment and Supplies.

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

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

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

2. **Ostomy Supplies.** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.

3. **Durable Medical Equipment.** Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member’s home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment. GHO, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.

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

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

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

I. Tobacco Cessation.

MHCN: When provided through the MHCN, services related to tobacco cessation are covered, limited to (1) participation in one individual or group program per calendar year; (2) educational materials; and (3) approved pharmacy products provided the Member is actively participating in a GHO-designated tobacco cessation program.

Community Provider: Not covered.

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

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

The prescription drug Cost Share, as set forth in the Allowances Schedule, applies to each thirty (30) day supply. Cost Shares for single and multiple thirty (30) day supplies of a given prescription are payable at the time of delivery.

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

"Standard reference compendia" means the American Hospital Formulary Service-Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia-Drug Information, or other authoritative compendia as identified from time to time by the federal secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in healthcare journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Under the MHCN option, all drugs, supplies, medicines and devices must be obtained at a MHCN pharmacy and, unless approved by GHO in advance, be listed in the GHO drug formulary. Injectables that can be self-administered are also subject to the prescription drug Cost Share. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by GHO.

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

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; vitamins, including Legend (prescription) vitamins; and any other drugs, medicines and injections not listed as covered in the GHO drug formulary unless approved in advance by GHO as Medically Necessary.

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

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

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

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

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

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

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

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

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

   Services provided under involuntary commitment statutes shall be covered at facilities approved by GHO. Services for any involuntary court-ordered treatment program beyond seventy-two (72) hours shall be covered only if determined to be Medically Necessary by GHO's Medical Director, or his/her designee.

   Coverage for voluntary/involuntary Emergency inpatient psychiatric services is subject to the Emergency care benefit set forth in Section IV.L., including the twenty-four (24) hour notification and transfer provisions.

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

   Under the Community Provider option, inpatient mental health services are limited to the services rendered by a physician (licensed under RCW 18.71 and RCW 18.57); a psychologist (licensed under RCW 18.83); a community mental health agency licensed by the Washington State Department of Social and Health Services (pursuant to RCW 71.24); a master's level therapist (certified under RCW 18.19),

an advanced practice psychiatric nurse (licensed under RCW 18.79) or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located.

3. **Exclusions and Limitations for Outpatient and Inpatient Mental Health Treatment Services.** Covered Services are limited to those authorized by (a) GHO's Medical Director, or his/her designee under the MHCN option, or (b) the attending mental health provider and GHO's Medical Director, or his/her designee, under the Community Provider option, for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention.

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

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

L. Emergency/Urgent Care.

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

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

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

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

   a. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible;
   b. Transfer of care to a MHCN Provider; and
   c. Transfer to another MHCN Facility if transferability is medically possible as determined by the MHCN.

2. **At a Non-MHCN Facility.** Usual, Customary and Reasonable charges for Emergency care for Covered Services are covered subject to:

   a. Payment of the Emergency care ***Cost Share***; and
   b. Notification of GHO by way of the GHO Notification Line within twenty-four (24) hours following inpatient admission, or as soon thereafter as medically possible.

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

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

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

4. **Transfer and Follow-up Care.** If a Member is hospitalized in a non-MHCN Facility, GHO reserves the right to require transfer of the Member to a MHCN Facility, upon consultation between a MHCN Provider and the attending physician. If the Member refuses to transfer to a MHCN Facility, all services received will be covered under the Community Provider option of the Inpatient Hospital Services section set forth in the Allowances Schedule.

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

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

Under the MHCN option, care for Urgent Conditions is covered at MHCN medical centers, MHCN urgent care clinics or MHCN Providers' offices, subject to the applicable Cost Share. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN Provider.

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

M. Ambulance Services.

1. **Emergency Transport to any Facility.** Each Emergency is covered as set forth in the Allowances Schedule. Ambulance services under the MHCN option are covered provided that the service is authorized in advance by a MHCN Provider or meets the definition of an Emergency (see Section VIII.).

2. **Interfacility Transfers.**

   a. **MHCN-Initiated Transfers.** MHCN-initiated non-emergent transfers to or from a MHCN Facility are covered as set forth in the Allowances Schedule.
   b. **Community Provider-Initiated Transfers.** When prescribed by the attending physician, transport from a medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered as set forth in the Allowances Schedule.

N. Skilled Nursing Facility (SNF). Skilled nursing care in a GHO-approved skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, is covered as set forth in the Allowances Schedule. Under the Community Provider option, skilled nursing care must be authorized in advance by GHO.

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

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

Section V. General Exclusions

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

1. Services or supplies not specifically listed as covered in the Schedule of Benefits, Section IV.

2. Except as specifically listed and identified as covered in Sections IV.B., IV.D., IV.H. and IV.J., corrective appliances and artificial aids including: eyeglasses; contact lenses and services related to their fitting; hearing devices and hearing aids, including related examinations; take-home drugs, dressings and supplies following

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

3. Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided in Section IV.D.

4. Convalescent or custodial care.

5. Durable medical equipment such as hospital beds, wheelchairs and walk-aids, except while in the hospital or as set forth in Section IV.B., IV.E., IV.F. or IV.H.

6. Services rendered as a result of work-related injuries, illnesses or conditions, including injuries, illnesses or conditions incurred as a result of self-employment.

7. Those parts of an examination and associated reports and immunizations required for employment, unless otherwise noted in Section IV.B., immigration, license, travel or insurance purposes that are not deemed Medically Necessary by GHO for early detection of disease.

8. Services and supplies related to sexual reassignment surgery, such as sex change operations or transformations and procedures or treatments designed to alter physical characteristics.

9. Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless otherwise noted in Section IV.B.

10. Any services to the extent benefits are "available" to the Member as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the Member asserts a claim or not, pursuant to medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the Member if the Member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.

    The Member and his/her agents must cooperate fully with GHO in its efforts to enforce this exclusion. This cooperation shall include supplying GHO with information about, or related to, the availability of other insurance coverage. The Member and his/her agent shall permit GHO, at GHO's option, to associate with the Member or to intervene in any action filed against any party related to the injury. The Member and his/her agents shall do nothing to prejudice GHO's right to enforce this exclusion. In the event the Member fails to cooperate fully, GHO reserves the right to deny coverage and the Member shall be responsible for reimbursing GHO for such medical expenses.

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

    GHO shall not pay any attorneys' fees or collection costs to attorneys representing the injured person where it has retained its own legal counsel or acts on its own behalf to represent its interests and unless there is a written fee agreement signed by GHO prior to any collection efforts. Under no circumstances will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery and/or which do not benefit GHO.

11. ***Late term pregnancy termination except when the health of the mother is at risk.***

12. The cost of services and supplies resulting from a Member's loss of or willful damage to appliances, devices, supplies and materials covered by GHO for the treatment of disease, injury or illness.

13. Orthoptic therapy (i.e., eye training).

14. Specialty treatment programs such as weight reduction, “behavior modification programs” and rehabilitation, including cardiac rehabilitation.

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

16. Procedures and services to reverse a therapeutic or nontherapeutic sterilization.

17. Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental service not specifically listed as covered in Section IV. GHO’s Medical Director, or his/her designee, will determine whether the care or treatment required is within the category of dental care or service.

18. Drugs, medicines and injections, except as set forth in Section IV.J. Any exclusion of drugs, medicines and injections, including those not listed as covered in the GHO drug formulary (approved drug list), will also exclude their administration.

19. Experimental or investigational services.

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

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

    b. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:
        i. The Member’s medical records,
        ii. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
        iii. Any consent document(s) the Member or Member’s representative has executed or will be asked to execute, to receive the service,
        iv. The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
        v. The published authoritative medical or scientific literature regarding the service, as applied to the Member’s illness or injury, and

vi. Regulations, records, applications and any other documents or actions issued by, filed with or taken by, the FDA or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Appeals regarding denial of coverage can be submitted to the Member Appeals Department, or to GHO's Medical Director at P.O. Box 34593, Seattle, WA 98124-1593. GHO will respond in writing within twenty (20) working days of the receipt of a fully documented appeal request. An expedited appeal is available if a delay would jeopardize the Member's life or health.

20. ***Chemical dependency, rehabilitation services and*** mental health care, except as specifically provided in Sections ***IV.C., IV.G.*** and IV.K.

21. Hypnotherapy, and all services related to hypnotherapy.

22. Genetic testing and related services, unless determined Medically Necessary by GHO's Medical Director, or his/her designee, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in Section IV.B. Testing for non-Members is also excluded.

23. Follow-up visits related to a non-Covered Service.

24. Fetal ultrasound in the absence of medical indications.

25. Routine foot care, except in the presence of a non-related Medical Condition affecting the lower limbs.

26. Complications of non-Covered Services.

27. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth in Section IV.B.

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

29. Autopsy and associated expenses.

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

31. Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered in Section IV.B.

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

33. Pre-Existing Conditions, except as specifically provided in Section IV.B.25.

Section VI. Grievance Processes for Complaints and Appeals

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

Filing a Complaint or Appeal

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

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

Complaint Process

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

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

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

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

Appeals Process

Step 1: If the Member wishes to appeal a decision denying benefits, he/she must submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why he/she disagrees with the decision. The appeal must be submitted within 180 days of the denial notice he/she received. Appeals should be directed to GHO's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593, toll free (866) 458-5479.

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

If the appeal request is for an experimental or investigational exclusion or limitation, GHO will make a determination and notify the Member in writing within twenty (20) working days of receipt of a fully documented request. In the event that additional time is required to make a determination, GHO will notify the Member in writing that an extension in the review timeframe is necessary. Under no circumstances will the review timeframe exceed twenty (20) days without the Member's written permission.

There is an expedited appeals process in place for cases which meet criteria or where the Member's provider believes that the standard thirty (30) day appeal review process will seriously jeopardize the Member's life, health or ability to regain maximum function or subject the Member to severe pain that cannot be managed adequately without the requested care or treatment. The Member can request an expedited appeal in writing to the above address, or by calling GHO's Member Appeals Department toll free (866) 458-5479. The Member's request for an expedited appeal will be processed and a decision issued no later than seventy-two (72) hours after receipt.

Step 2: If the Member is not satisfied with the decision in Step 1 regarding a denial of benefits, or if GHO fails to grant or reject the Member's request within the applicable required timeframe, he/she may request a second level review by an external independent review organization as set forth under subsection A. below. The Member may also choose to pursue review by an appeals committee prior to requesting a review by an independent review organization as set forth under subsection B. below. This is not a required step in the appeals process.

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

A request for a review by an independent review organization must be made within 180 days after the date of the Step 1 decision notice, or within 180 days after the date of a GHO appeals committee decision notice.

B. Request an optional hearing by the GHO appeals committee:

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

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

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

A request for a hearing by the appeals committee must be made within thirty (30) days after the date of the Step 1 decision notice. The request can be mailed to GHO's Member Appeals Department, P.O. Box 34593, Seattle, WA 98124-1593. *

* If the Member's health plan is governed by the Employee Retirement Income Security Act, known as "ERISA" (most employment related health plans, other than those sponsored by governmental entities or churches – ask employer about plan), the Member has the right to file a lawsuit under Section 502(a) of ERISA to recover benefits due to the Member under the plan at any point after completion of Step 1 of the appeals process. Members may have other legal rights and remedies available under state or federal law.

Section VII. General Provisions

A. Coordination of Benefits

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

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

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

1. Definitions.

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

1) Plan includes: group, individual or blanket disability insurance contracts and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care

contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

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

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

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

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

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

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

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

2. Order of Benefit Determination Rules.

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

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

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

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

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

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

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

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

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

b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual

knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;

(2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of a) above determine the order of benefits;

(4) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection a) above determine the order of benefits; or

(5) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the non-custodial parent, third; and then
- The plan covering the spouse of the non-custodial parent, last.

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

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

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

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

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

3. Effect on the Benefits of this Plan.

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

4. **Right to Receive and Release Needed Information.**

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

5. **Facility of Payment.**

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

6. **Right of Recovery.**

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

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

7. **Effect of Medicare.**

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

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

b. When a Member, who is a Medicare beneficiary and for whom Medicare has been determined to be the primary bill payer under Medicare secondary payer guidelines and regulations, seeks care on a Self-Referred basis from Community Providers, GHO has no obligation to provide any benefits except as specifically outlined in the Community Provider option under Section IV.

B. Subrogation and Reimbursement Rights

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

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

If the Injured Person’s injuries were caused by a third party giving rise to a claim of legal liability against the third party and/or payment by the third party to the Injured Person and/or a settlement between the third party

and the Injured Person, GHO shall have the right to recover GHO's Medical Expenses from any source available to the Injured Person as a result of the events causing the injury, including but not limited to funds available through applicable third party liability coverage and uninsured/underinsured motorist coverage. This right is commonly referred to as "subrogation." GHO shall be subrogated to and may enforce all rights of the Injured Person to the extent of GHO's Medical Expenses.

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

Subject to the above provisions, if the Injured Person is entitled to or does receive money from any source as a result of the events causing the injury, including but not limited to any party's liability insurance or uninsured/underinsured motorist funds, then GHO's Medical Expenses provided or to be provided to the Injured Person are secondary, not primary. As a condition of receiving benefits under the Agreement, the Injured Person agrees that acceptance of GHO services is constructive notice of this provision in its entirety and agrees to reimburse GHO for the benefits the Injured Person received as a result of the events causing the injury.

The Injured Person and his/her agents shall cooperate fully with GHO in its efforts to collect GHO's Medical Expenses. This cooperation includes, but is not limited to, supplying GHO with information about any third parties, defendants and/or insurers related to the Injured Person's claim and informing GHO of any settlement or other payments relating to the Injured Person's injury. The Injured Person and his/her agents shall permit GHO, at GHO's option, to associate with the Injured Person or to intervene in any legal, quasi-legal, agency or any other action or claim filed. If the Injured Person takes no action to recover money from any source, then the Injured Person agrees to allow GHO to initiate its own direct action for reimbursement or subrogation, including, but not limited to, billing the Injured Person directly for GHO's Medical Expenses.

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

To the extent that the Injured Person recovers funds from any source that may serve to compensate for medical injuries or medical expenses, the Injured Person agrees to hold such monies in trust or in their possession until GHO's subrogation and reimbursement rights are fully determined.

GHO shall not pay any attorneys' fees or collection costs to attorneys representing the Injured Person unless there is a written fee agreement signed by GHO prior to any collection efforts. When reasonable collection costs have been incurred with GHO's prior written agreement to recover GHO's Medical Expenses, there shall be an equitable apportionment of such collection costs between GHO and the Injured Person subject to a maximum responsibility of GHO equal to one-third of the amount recovered on behalf of GHO. Under no circumstance will GHO pay legal fees for services which were not reasonably and necessarily incurred to secure recovery, which do not benefit GHO or where no written fee agreement has been entered into with GHO.

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

C. Miscellaneous Provisions

1. **Identification Cards.** GHO will furnish cards, for identification purposes only, to all Members enrolled under the Agreement.

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

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

4. **Confidentiality.** GHO and the Group shall keep Member information strictly confidential and shall not disclose any information to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to the Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of the Agreement and agree to abide by them, (ii) pursuant to court order or (iii) to a designated public official or agency pursuant to the requirements of federal, state or local law, statute, rule or regulation.

5. **Nondiscrimination.** GHO does not discriminate on the basis of physical or mental disabilities in its employment practices and services.

D. Utilization Management

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

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

Section VIII. Definitions

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

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

Community Provider: Physicians licensed under 18.71 or 18.57 RCW, registered nurses licensed under 18.79 RCW, midwives licensed under 18.79 RCW, naturopaths licensed under 18.36A RCW, acupuncturists licensed under 18.06 RCW, podiatrists licensed under 18.22 RCW or, in the case of non-Washington State providers, those providers meeting equivalent licensing and certification requirements established in the state where the provider's practice is located. For purposes of the Agreement, Community Providers do not include individuals employed by or under contract with the MHCN or who provide a service or treat Members outside the scope of their licenses.

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

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

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

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

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

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

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

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

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

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

Hospital Care: Those Medically Necessary services generally provided by acute general hospitals for admitted patients. Hospital Care does not include convalescent or custodial care, which can, in the opinion of the provider, be provided by a nursing home or convalescent care center.

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

Managed Health Care Network (MHCN): The participating provider with which GHO has entered into a written participating provider agreement for the provision of Covered Services. GHO's participating provider is Group Health Cooperative.

Medical Condition: A disease, illness or injury.

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

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

Member: Any Subscriber or Dependent enrolled under the Agreement.

MHCN-Designated Self-Referral Specialist: A MHCN specialist specifically identified by GHO to whom Members may self-refer.

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

MHCN Personal Physician: A provider who is employed by or contracted with the MHCN 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 a Referral. Personal Physicians must be capable of and licensed to provide the majority of primary health care services required by each Member.

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

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

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

Plan Coinsurance: The percentage amount the Member and GHO are required to pay for Covered Services received under the Agreement. Percentages for Covered Services are set forth in the Allowances Schedule.

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

Preferred Community Provider: A Community Provider that has agreed to accept from GHO a contracted rate for Covered Services under Section IV. Services received from a Preferred Community Provider are subject to a discounted rate, less any Cost Shares set forth in the Allowances Schedule.

Preferred Community Provider Contracted Rate: The discounted rate that the Preferred Community Provider has agreed to accept from GHO for medical services received by Members.

Referral: A written temporary agreement requested in advance by a MHCN Personal Physician and approved by GHO that entitles a Member to receive Covered Services from a specified health care provider at the MHCN benefit level. Entitlement to such services shall not exceed the limits of the Referral and is subject to all terms and conditions of the Referral and the Agreement. Members who have a complex or serious medical or psychiatric condition may receive a standing Referral for specialist services.

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

Self-Referred: Covered Services received by a Member from a Community Provider, designated women's health care specialist, or MHCN-Designated Self-Referral Specialist that are not referred by a MHCN Personal Physician.

Service Area: Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by GHO.

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

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

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

PREMIUM SCHEDULE

Group Name	**Hanford Employee Welfare Trust (HEWT) - HAMTC-Represented and I**		
Group Number (Primary/Secondary)	**6813500/6227600**		
GROUP HEALTH OPTIONS INC. - Options benefit description			
Inside the Network: Managed Care Providers		***Outside the Network: Non Managed Care Providers***	
Coinsurance	80/20%	Coinsurance	70/30%
Deductible	$100	Deductible	$200
Emergency Copay	$75	Emergency Copay	$125
Family Ded & OOP Max	2x	Family Ded & OOP Max	2x
Hospital Inpatient Copay	None	Hospital Inpatient Copay	None
Office Visit Copay	None	Office Visit Copay	None
Optical Rider	$165/24 months	Optical Rider	CUSTOMIZED LANGU
Out Of Pocket	$1000	Out Of Pocket Threshold	$2875
Outpatient Surgery Copay	Same as OV	Outpatient Surgery Copay	Same as OON OV
Prescription Drug Copay	$15/$30	Prescription Drug Copay	$20/$35
No PEC Wait		Group Offering	Dual Choice
MONTHLY HEALTHCARE PREMIUM			
This Schedule reflects from: 01/01/2010 to 01/01/2011			
Subscriber	$470.91		
Subscriber and 1 Dependent	$861.76		
Subscriber and 2 Dependents	$1,445.69		