

# Summary of benefits

Clear Care Prestige (PPO)

Clear Care Elite (PPO)

**BENEFITS EFFECTIVE:**

JAN 1, 2011– DEC 31, 2011

**COUNTIES SERVED:**

Benton, Franklin, Yakima,  
and parts of Clallam  
and Jefferson



# Section I: Introduction to Summary of Benefits

Thank you for your interest in Group Health Options Clear Care Prestige (PPO) and Clear Care Elite (PPO). Our plans are offered by GROUP HEALTH OPTIONS/Group Health Options, Inc., a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Group Health Options and ask for the "Evidence of Coverage."

## You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Group Health Options Clear Care Prestige (PPO) and Clear Care Elite (PPO) plans. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Group Health Options Clear Care at the number listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information.

TTY/TDD users should call **1-877-486-2048**.

You can call this number 24 hours a day, 7 days a week.

## How can I compare my options?

You can compare Group Health Options Clear Care Prestige (PPO) and Clear Care Elite (PPO) plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

## Where are Group Health Options Clear Care Prestige (PPO) and Clear Care Elite (PPO) plans available?

The service area for these plans include: Benton, Clallam\*, Franklin, Jefferson\*, Yakima Counties, WA. You must live in one of these areas to join the plan.

\* denotes partial county

## Who is eligible to join Group Health Options Clear Care (PPO) plans?

You can join Group Health Options Clear Care (PPO) plans if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Group Health Options Clear Care plans unless they are members of our organization and have been since their dialysis began.

## Can I choose my doctors?

Group Health Options Clear Care (PPO) plans have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at <http://www.ghc.org/provider/index.jhtml>.

Our customer service number is listed at the end of this introduction.

### **What happens if I go to a doctor who's not in your network?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the Customer Service number listed at the end of this introduction.

### **Where can I get my prescriptions if I join this plan?**

Group Health Options Clear Care (PPO) plans have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.ghc.org](http://www.ghc.org). Our Customer Service number is listed at the end of this introduction.

### **Does my plan cover Medicare part B or part D drugs?**

Group Health Options Clear Care Prestige (PPO) and Clear Care Elite (PPO) plans do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

### **What is a prescription drug formulary?**

Group Health Options Clear Care (PPO) plans use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete

formulary on our Web site at [www.ghc.org/health\\_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html](http://www.ghc.org/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

### **How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?**

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**, 24 hours a day/7 days a week; and see [www.medicare.gov](http://www.medicare.gov) 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call **1-800-325-0778**; or
- Your State Medicaid Office.

### **What are my protections in the Clear Care Prestige and Clear Care Elite (PPO) plans?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a

# Section I: Introduction to the Summary of Benefits

plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of a Group Health Options (PPO) plan, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of the Group Health Options Clear Care Prestige (PPO) or Clear Care Elite (PPO) plans, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and right to file a grievance. You have the right to request a coverage determination if you want us to cover

a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

## **What is a Medication Therapy Management (MTM) Program?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Group Health Options for more details.

## **What types of drugs may be covered under Medicare part B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following

types of drugs. Contact Group Health Options for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs** provided through DME.

### **Where can I find information on plan ratings?**

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on

**www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our Customer Service number is listed to the right.

Please call Group Health Options, Inc. for more information about Group Health Options Clear Care (PPO) plans. Visit us at **www.ghc.org/medicare** or call us:

#### **Customer Service Hours:**

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m.–8:00 p.m. Pacific

Current members should call toll-free **(888)-901-4600** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD **(800)-833-6388**)

Prospective members should call toll-free **(800)-446-8882** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD **(800)-833-6388**)

Current members should call locally **(206)-901-4600** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD **(800)-833-6388**)

Prospective members should call locally **(800)-446-8882** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug Program. (TTY/TDD **(800)-833-6388**)

For more information about Medicare, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit **www.medicare.gov** on the web.

If you have special needs, this document may be available in other formats or languages.

# Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<p data-bbox="82 275 488 317">Important Information</p> <p data-bbox="82 352 480 426"><b>1 Premium and Other Important Information</b></p>	<p data-bbox="862 352 1500 499">Most people will continue to pay the Part B premium amount they paid in 2010. Depending on when you signed up for Medicare Part B, this amount is \$96.40 or \$110.50.</p> <p data-bbox="862 520 1479 594">In 2011 the monthly Part B premium is \$115.40 and the yearly Part B deductible amount is \$162.</p> <p data-bbox="862 615 1528 720">If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p data-bbox="862 741 1528 1098">Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at <b>1-800-MEDICARE (1-800-633-4227)</b>. TTY users should call <b>1-877-486-2048</b>. You may also call Social Security at <b>1-800-772-1213</b>. TTY users should call <b>1-800-325-0778</b>.</p>
<p data-bbox="82 1675 740 1791"><b>2 Doctor and Hospital Choice</b> (For more information, see Emergency Care—#15 and Urgently Needed Care—#16)</p>	<p data-bbox="862 1675 1568 1749">You may go to any doctor, specialist, or hospital that accepts Medicare.</p>

## CLEAR CARE PRESTIGE PPO

## CLEAR CARE ELITE PPO

### GENERAL

\$71 monthly plan premium in addition to your monthly Medicare Part B premium.

Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher Part B and Part D premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may also call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

This plan covers all Medicare-covered preventive services with zero cost sharing.

### IN AND OUT-OF-NETWORK

\$3,200 out-of-pocket limit.

There is no limit on cost sharing for the following services:

#### IN-NETWORK:

##### Supplemental Services:

- Preventive Dental
- Comprehensive Dental
- Eye Wear
- Hearing Aids

#### OUT-OF-NETWORK:

##### Supplemental Services:

- Preventive Dental
- Comprehensive Dental
- Eye Wear
- Hearing Aids

### IN-NETWORK

No referral required for network doctors, specialists, and hospitals.

### IN AND OUT-OF-NETWORK

You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.

### GENERAL

\$109 monthly plan premium in addition to your monthly Medicare Part B premium.

Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher Part B and Part D premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may also call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

This plan covers all Medicare-covered preventive services with zero cost sharing.

### IN AND OUT-OF-NETWORK

\$2,500 out-of-pocket limit.

There is no limit on cost sharing for the following services:

#### IN-NETWORK:

##### Supplemental Services:

- Preventive Dental
- Comprehensive Dental
- Eye Wear
- Hearing Aids

#### OUT-OF-NETWORK:

##### Supplemental Services:

- Preventive Dental
- Comprehensive Dental
- Eye Wear
- Hearing Aids

### IN-NETWORK

No referral required for network doctors, specialists, and hospitals.

### IN AND OUT-OF-NETWORK

You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.

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BENEFIT	ORIGINAL MEDICARE
<p data-bbox="82 275 342 317">Inpatient Care</p> <p data-bbox="82 338 548 457"><b>3 Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<p data-bbox="862 338 1487 373">In 2011 the amounts for each benefit period are:</p> <ul data-bbox="862 401 1468 531" style="list-style-type: none"><li>• Days 1–60: \$1132 deductible</li><li>• Days 61–90: \$283 per day</li><li>• Days 91–150: \$566 per lifetime reserve day</li></ul> <p data-bbox="862 558 1484 627">Call <b>1-800-MEDICARE (1-800-633-4227)</b> for information about lifetime reserve days.</p> <p data-bbox="862 648 1458 684">Lifetime reserve days can only be used once.</p> <p data-bbox="862 705 1528 1026">A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>
<p data-bbox="82 1087 581 1123"><b>4 Inpatient Mental Health Care</b></p>	<p data-bbox="862 1087 1479 1157">Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above)</p> <p data-bbox="862 1178 1458 1213">190 day lifetime limit in a Psychiatric Hospital</p>

## CLEAR CARE PRESTIGE PPO

## CLEAR CARE ELITE PPO

### IN-NETWORK

No limit to the number of days covered by the plan each benefit period

#### For Medicare-covered hospital stays:

- Days 1–5: \$200 copay per day
- Days 6–90: \$0 copay per day

The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.

\$0 copay for additional hospital days

### OUT-OF-NETWORK

#### For hospital stays:

- Days 1–5: \$400 copay per day
- Days 6 and beyond: \$0 copay per day

### IN-NETWORK

No limit to the number of days covered by the plan each benefit period

#### For Medicare-covered hospital stays:

- Days 1–5: \$100 copay per day
- Days 6–90: \$0 copay per day

The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.

\$0 copay for additional hospital days

### OUT-OF-NETWORK

#### For hospital stays:

- Days 1–5: \$300 copay per day
- Days 6 and beyond: \$0 copay per day

### IN-NETWORK

You get up to 190 days in a Psychiatric Hospital in a lifetime.

#### For Medicare-covered hospital stays:

- Days 1–5: \$200 copay per day
- Days 6–90: \$0 copay per day

The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

### OUT-OF-NETWORK

#### For hospital stays:

- Days 1–5: \$400 copay per day
- Days 6 and beyond: \$0 copay per day

### IN-NETWORK

You get up to 190 days in a Psychiatric Hospital in a lifetime.

#### For Medicare-covered hospital stays:

- Days 1–5: \$100 copay per day
- Days 6–90: \$0 copay per day

The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

### OUT-OF-NETWORK

#### For hospital stays:

- Days 1–5: \$300 copay per day
- Days 6 and beyond: \$0 copay per day

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BENEFIT	ORIGINAL MEDICARE
<p><b>5 Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <ul style="list-style-type: none"> <li>• Days 1–20: \$0 per day</li> <li>• Days 21–100: \$141.50 per day</li> </ul> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>
<p><b>6 Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay</p>
<p><b>7 Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.</p>
<p>Outpatient Care</p>	
<p><b>8 Doctor Office Visits</b></p>	<p>20% coinsurance</p>

If you have any questions about these plans' benefits or costs, please contact Group Health Options, Inc. for details.

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> Plan covers up to 100 days each benefit period No prior hospital stay is required.</p> <p><b>For Medicare-covered SNF stays:</b> Days 1–100: \$50 copay per day</p> <p><b>OUT-OF-NETWORK</b> <b>For each SNF stay:</b> Days 1–100: \$75 copay per SNF day</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> Plan covers up to 100 days each benefit period No prior hospital stay is required.</p> <p><b>For Medicare-covered SNF stays:</b> Days 1–100: \$25 copay per day</p> <p><b>OUT-OF-NETWORK</b> <b>For each SNF stay:</b> Days 1–100: \$50 copay per SNF day</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits.</p> <p><b>OUT-OF-NETWORK</b> 20% for home health visits.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits.</p> <p><b>OUT-OF-NETWORK</b> 20% for home health visits.</p>
<p><b>GENERAL</b> You must get care from a Medicare-certified hospice.</p>	<p><b>GENERAL</b> You must get care from a Medicare-certified hospice.</p>
<p><b>GENERAL</b> See “Welcome to Medicare; and Annual Wellness Visit”, for more information.</p> <p><b>IN-NETWORK</b> \$20 copay for each primary care doctor visit for Medicare-covered benefits. \$20 copay for each in-area, network urgent care Medicare-covered visit. \$40 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>OUT-OF-NETWORK</b> \$35 copay for each primary care doctor visit. \$55 copay for each specialist visit.</p>	<p><b>GENERAL</b> See “Welcome to Medicare; and Annual Wellness Visit”, for more information.</p> <p><b>IN-NETWORK</b> \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 copay for each in-area, network urgent care Medicare-covered visit. \$30 copay for each specialist visit for Medicare-covered benefits.</p> <p><b>OUT-OF-NETWORK</b> \$25 copay for each primary care doctor visit. \$45 copay for each specialist visit.</p>

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BENEFIT	ORIGINAL MEDICARE
<p><b>9 Chiropractic Services</b></p>	<p>Routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
<p><b>10 Podiatry Services</b></p>	<p>Routine care not covered</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>
<p><b>11 Outpatient Mental Health Care</b></p>	<p>45% coinsurance for most outpatient mental health services.</p>
<p><b>12 Outpatient Substance Abuse Care</b></p>	<p>20% coinsurance</p>
<p><b>13 Outpatient Services/Surgery</b></p>	<p>20% coinsurance for the doctor</p> <p>Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility charges</p>

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>IN-NETWORK</b> \$20 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>OUT-OF-NETWORK</b> \$35 copay for chiropractic benefits.</p>	<p><b>IN-NETWORK</b> \$10 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><b>OUT-OF-NETWORK</b> \$25 copay for chiropractic benefits.</p>
<p><b>IN-NETWORK</b> \$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>OUT-OF-NETWORK</b> \$55 copay for podiatry benefits.</p>	<p><b>IN-NETWORK</b> \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p><b>OUT-OF-NETWORK</b> \$45 copay for podiatry benefits.</p>
<p><b>IN-NETWORK</b> \$20 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>OUT-OF-NETWORK</b> \$35 copay for Mental Health benefits. \$35 copay for Mental Health benefits with a psychiatrist.</p>	<p><b>IN-NETWORK</b> \$10 copay for each Medicare-covered individual or group therapy visit.</p> <p><b>OUT-OF-NETWORK</b> \$25 copay for Mental Health benefits. \$25 copay for Mental Health benefits with a psychiatrist.</p>
<p><b>IN-NETWORK</b> \$20 copay for Medicare-covered individual or group visits.</p> <p><b>OUT-OF-NETWORK</b> \$35 copay for outpatient substance abuse benefits.</p>	<p><b>IN-NETWORK</b> \$10 copay for Medicare-covered individual or group visits.</p> <p><b>OUT-OF-NETWORK</b> \$25 copay for outpatient substance abuse benefits.</p>
<p><b>IN-NETWORK</b> \$200 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>OUT-OF-NETWORK</b> \$400 copay for ambulatory surgical center benefits. \$400 copay for outpatient hospital facility benefits.</p>	<p><b>IN-NETWORK</b> \$100 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit.</p> <p><b>OUT-OF-NETWORK</b> \$300 copay for ambulatory surgical center benefits. \$300 copay for outpatient hospital facility benefits.</p>

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<p><b>14 Ambulance Services</b> (medically necessary ambulance services)</p>	<p>20% coinsurance</p>
<p><b>15 Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>Specified copayment for outpatient hospital emergency room (ER) facility charge.</p> <p>ER Copay cannot exceed Part A inpatient hospital deductible.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
<p><b>16 Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
<p><b>17 Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)</p>	<p>20% coinsurance</p>

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>IN-NETWORK</b> \$150 copay for Medicare-covered ambulance benefits.</p> <p><b>OUT-OF-NETWORK</b> \$150 copay for ambulance benefits.</p>	<p><b>IN-NETWORK</b> \$100 copay for Medicare-covered ambulance benefits.</p> <p><b>OUT-OF-NETWORK</b> \$100 copay for ambulance benefits.</p>
<p><b>GENERAL</b> \$50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>	<p><b>GENERAL</b> \$50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visit</p>
<p><b>GENERAL</b> \$20 copay for Medicare-covered urgently needed care visits.</p>	<p><b>GENERAL</b> \$10 copay for Medicare-covered urgently needed care visits.</p>
<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$20 copay for Medicare-covered Occupational Therapy visits.</li> <li>• \$20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</li> <li>• \$20 copay for Medicare-covered Cardiac Rehab services.</li> </ul> <p><b>OUT-OF-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$35 copay for Occupational Therapy benefits.</li> <li>• \$35 copay for Physical and/or Speech and Language Therapy visits.</li> <li>• \$35 copay for Cardiac Rehab services.</li> </ul>	<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$10 copay for Medicare-covered Occupational Therapy visits.</li> <li>• \$10 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</li> <li>• \$10 copay for Medicare-covered Cardiac Rehab services.</li> </ul> <p><b>OUT-OF-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$25 copay for Occupational Therapy benefits.</li> <li>• \$25 copay for Physical and/or Speech and Language Therapy visits.</li> <li>• \$25 copay for Cardiac Rehab services.</li> </ul>

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<b>Outpatient Medical Services and Supplies</b>	
<b>18 Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	20% coinsurance
<b>19 Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance
<b>20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	20% coinsurance  Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

**CLEAR CARE PRESTIGE PPO**

**CLEAR CARE ELITE PPO**

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

20% of the cost for Medicare-covered items.

**OUT-OF-NETWORK**

40% of the cost for durable medical equipment.

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

20% of the cost for Medicare-covered items.

**OUT-OF-NETWORK**

40% of the cost for durable medical equipment.

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

20% of the cost for Medicare-covered items.

**OUT-OF-NETWORK**

40% of the cost for prosthetic devices.

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

20% of the cost for Medicare-covered items.

**OUT-OF-NETWORK**

40% of the cost for prosthetic devices.

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

\$0 copay for Diabetes self-monitoring training.

\$0 copay for Nutrition Therapy for Diabetes.

20% of the cost for Diabetes supplies.

**OUT-OF-NETWORK**

\$0 copay for Diabetes self-monitoring training.

\$0 copay for Nutrition Therapy for Diabetes.

40% of the cost for Diabetes supplies.

**GENERAL**

Authorization rules may apply.

**IN-NETWORK**

\$0 copay for Diabetes self-monitoring training.

\$0 copay for Nutrition Therapy for Diabetes.

20% of the cost for Diabetes supplies.

**OUT-OF-NETWORK**

\$0 copay for Diabetes self-monitoring training.

\$0 copay for Nutrition Therapy for Diabetes.

40% of the cost for Diabetes supplies.

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<p><b>21 Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b></p>	<p>20% coinsurance for diagnostic tests and x-rays \$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>
<p>Preventive Services</p>	
<p><b>22 Bone Mass Measurement</b> (for people with Medicare who are at risk)</p>	<p>No coinsurance, copayment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>
<p><b>23 Colorectal Screening Exams</b> (for people with Medicare age 50 and older)</p>	<p>No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy. Covered when you are high risk or when you are age 50 and older.</p>

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"><li>• lab services</li><li>• diagnostic procedures and tests</li></ul> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$75 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>\$0 copay for Medicare-covered therapeutic radiology services.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for diagnostic procedures, tests, and lab services.</p> <p>\$0 copay for outpatient x-rays.</p> <p>\$0 copay for therapeutic radiology services.</p> <p>\$150 copay for diagnostic radiology services.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"><li>• lab services</li><li>• diagnostic procedures and tests</li></ul> <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$50 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>\$0 copay for Medicare-covered therapeutic radiology services.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for diagnostic procedures, tests, and lab services.</p> <p>\$0 copay for outpatient x-rays.</p> <p>\$0 copay for therapeutic radiology services.</p> <p>\$100 copay for diagnostic radiology services.</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement.</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for colorectal screenings.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for colorectal screenings.</p>

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<p><b>24 Immunizations</b> (Flu vaccine, Hepatitis B vaccine— for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu, Pneumonia, and Hepatitis B vaccines.</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>
<p><b>25 Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)</p>	<p>No coinsurance, copayment or deductible.</p> <p>No referral needed</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>
<p><b>26 Pap Smears and Pelvic Exams</b> (for women with Medicare)</p>	<p>No coinsurance, copayment, or deductible for Pap smears.</p> <p>No coinsurance, copayment, or deductible for Pelvic and clinical breast exams.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p>
<p><b>27 Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p>	<p>20% coinsurance for the digital rectal exam</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>
<p><b>28 End-Stage Renal Disease</b></p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>

If you have any questions about these plans' benefits or costs, please contact Group Health Options, Inc. for details.

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>IN-NETWORK</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for immunizations.</p>	<p><b>IN-NETWORK</b> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for immunizations.</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for screening mammograms.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for screening mammograms.</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for pap smears and pelvic exams.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for pap smears and pelvic exams.</p>
<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for prostate cancer screening.</p>	<p><b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for prostate cancer screening.</p>
<p><b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p><b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<b>29 Prescription Drugs</b>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>

## CLEAR CARE PRESTIGE PPO

### Drugs covered under Medicare Part B

#### GENERAL

\$0 copay for Part B-covered drugs.

\$0 copay for Part B drugs out-of-network.

### Home Infusion Drugs, Supplies, and Services

\$0 copay for home infusion drugs that would normally be covered under part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.

### Drugs covered under Medicare Part D

#### GENERAL

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at [www.ghc.org/health\\_plansindexjhtml?reposit=/common/healthPlans/MedicareaboutPartDFormulary.html](http://www.ghc.org/health_plansindexjhtml?reposit=/common/healthPlans/MedicareaboutPartDFormulary.html) on the web. Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.

Total yearly drug costs are the total drug costs paid by both you and the plan.

Some drugs have quantity limits.

Your provider must get prior authorization from Group Health Options Clear Care Prestige (PPO) for certain drugs.

## CLEAR CARE ELITE PPO

### Drugs covered under Medicare Part B

#### GENERAL

\$0 copay for Part B-covered drugs.

\$0 copay for Part B drugs out-of-network.

### Home Infusion Drugs, Supplies, and Services

\$0 copay for home infusion drugs that would normally be covered under part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.

### Drugs covered under Medicare Part D

#### GENERAL

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at [www.ghc.org/health\\_plansindexjhtml?reposit=/common/healthPlans/MedicareaboutPartDFormulary.html](http://www.ghc.org/health_plansindexjhtml?reposit=/common/healthPlans/MedicareaboutPartDFormulary.html) on the web. Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.

Total yearly drug costs are the total drug costs paid by both you and the plan.

Some drugs have quantity limits.

Your provider must get prior authorization from Group Health Options Clear Care Elite (PPO) for certain drugs.

## Section II: Summary of Benefits

BENEFIT

ORIGINAL MEDICARE

## CLEAR CARE PRESTIGE PPO

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on **Medicare.gov**.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Group Health Options Clear Care Prestige (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.

### IN-NETWORK

\$310 yearly deductible.

### INITIAL COVERAGE

After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,840:

#### RETAIL PHARMACY

##### Tier 1: Preferred Generic Drugs

- \$6 copay for a one-month (30-day) supply of drugs in this tier
- \$18 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

##### Tier 2: Preferred Brand Drugs

- \$17 copay for a one-month (30-day) supply of drugs in this tier
- \$51 copay for a three-month (90-day) supply of drugs in this tier

## CLEAR CARE ELITE PPO

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on **Medicare.gov**.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Group Health Options Clear Care Elite (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.

### IN-NETWORK

\$0 deductible

### INITIAL COVERAGE

You pay the following until total yearly drug costs reach \$2,840:

#### RETAIL PHARMACY

##### Tier 1: Preferred Generic Drugs

- \$9 copay for a one-month (30-day) supply of drugs in this tier
- \$27 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

##### Tier 2: Preferred Brand Drugs

- \$15 copay for a one-month (30-day) supply of drugs in this tier
- \$45 copay for a three-month (90-day) supply of drugs in this tier

## Section II: Summary of Benefits

BENEFIT

ORIGINAL MEDICARE

## CLEAR CARE PRESTIGE PPO

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier
- 50% coinsurance for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

## CLEAR CARE ELITE PPO

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier
- 50% coinsurance for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

## LONG TERM CARE PHARMACY

### Tier 1: Preferred Generic Drugs

- \$6 copay for a one-month (31-day) supply of drugs in this tier

### Tier 2: Preferred Brand Drugs

- \$17 copay for a one-month (31-day) supply of drugs in this tier

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (31-day) supply of drugs in this tier

## LONG TERM CARE PHARMACY

### Tier 1: Preferred Generic Drugs

- \$9 copay for a one-month (31-day) supply of drugs in this tier

### Tier 2: Preferred Brand Drugs

- \$15 copay for a one-month (31-day) supply of drugs in this tier

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (31-day) supply of drugs in this tier

## MAIL ORDER

### Tier 1: Preferred Generic Drugs

- \$6 copay for a one-month (30-day) supply of drugs in this tier
- \$18 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

## MAIL ORDER

### Tier 1: Preferred Generic Drugs

- \$9 copay for a one-month (30-day) supply of drugs in this tier
- \$27 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

## Section II: Summary of Benefits

BENEFIT

ORIGINAL MEDICARE

## CLEAR CARE PRESTIGE PPO

### Tier 2: Preferred Brand Drugs

- \$17 copay for a one-month (30-day) supply of drugs in this tier
- \$51 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier
- 50% coinsurance for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### COVERAGE GAP

After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

### CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or
- 5% coinsurance

### OUT-OF-NETWORK

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Group Health Options Clear Care Prestige (PPO).

## CLEAR CARE ELITE PPO

### Tier 2: Preferred Brand Drugs

- \$15 copay for a one-month (30-day) supply of drugs in this tier
- \$45 copay for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier
- 50% coinsurance for a three-month (90-day) supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

### COVERAGE GAP

After your total yearly drug costs reach \$2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,550.

### CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or
- 5% coinsurance

### OUT-OF-NETWORK

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Group Health Options Clear Care Elite (PPO).

## Section II: Summary of Benefits

BENEFIT

ORIGINAL MEDICARE

## CLEAR CARE PRESTIGE PPO

### OUT-OF-NETWORK INITIAL COVERAGE

After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:

#### Tier 1: Preferred Generic Drugs

- \$6 copay for a one-month (30-day) supply of drugs in this tier

#### Tier 2: Preferred Brand Drugs

- \$17 copay for a one-month (30-day) supply of drugs in this tier

#### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier

## CLEAR CARE ELITE PPO

### OUT-OF-NETWORK INITIAL COVERAGE

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,840:

#### Tier 1: Preferred Generic Drugs

- \$9 copay for a one-month (30-day) supply of drugs in this tier

#### Tier 2: Preferred Brand Drugs

- \$15 copay for a one-month (30-day) supply of drugs in this tier

#### Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs

- 50% coinsurance for a one-month (30-day) supply of drugs in this tier

### OUT-OF-NETWORK COVERAGE GAP

You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

### OUT-OF-NETWORK COVERAGE GAP

You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,550.

### OUT-OF-NETWORK CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or
- 5% coinsurance.

### OUT-OF-NETWORK CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of:

- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or
- 5% coinsurance.

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<b>30 Dental Services</b>	Preventive dental services (such as cleaning) not covered.
<b>31 Hearing Services</b>	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.
<b>32 Vision Services</b>	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.

### CLEAR CARE PRESTIGE PPO

#### IN-NETWORK

In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")

0% of the cost for Medicare-covered dental benefits.

#### OUT-OF-NETWORK

\$0 copay for comprehensive dental benefits.

#### IN-NETWORK

Hearing aids not covered.

\$20 copay for Medicare-covered diagnostic hearing exams

\$20 copay for up to 1 routine hearing test(s)

\$0 copay for up to 1 hearing aid fitting evaluation(s)

#### OUT-OF-NETWORK

\$35 copay for hearing exams.

#### IN-NETWORK

\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.

\$0 to \$20 copay for exams to diagnose and treat diseases and conditions of the eye.

\$0 copay for up to 1 routine eye exam(s) every year.

#### OUT-OF-NETWORK

\$35 copay for eye exams.

\$0 copay for eye wear.

### CLEAR CARE ELITE PPO

#### IN-NETWORK

In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits.")

0% of the cost for Medicare-covered dental benefits.

#### OUT-OF-NETWORK

\$0 copay for comprehensive dental benefits.

#### IN-NETWORK

Hearing aids not covered.

\$10 copay for Medicare-covered diagnostic hearing exams

\$10 copay for up to 1 routine hearing test(s)

\$0 copay for up to 1 hearing aid fitting evaluation(s)

#### OUT-OF-NETWORK

\$25 copay for hearing exams.

#### IN-NETWORK

\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.

\$0 to \$10 copay for exams to diagnose and treat diseases and conditions of the eye.

\$0 copay for up to 1 routine eye exam(s) every year.

#### OUT-OF-NETWORK

\$25 copay for eye exams.

\$0 copay for eye wear.

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<b>33 Welcome to Medicare; and Annual Wellness Visit</b>	<p>When you join Medicare Part B, then you are eligible as follows.</p> <p>During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.</p>
<b>34 Health/Wellness Education</b>	<p><b>Smoking Cessation:</b> Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p> <p>\$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months of up to three times during a pregnancy.</p>
<b>Transportation (Routine)</b>	Not covered.

CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
<p><b>IN-NETWORK</b> \$0 copay for routine exams. Limited to 1 exam(s) every year.</p> <p><b>OUT-OF-NETWORK</b> \$35 copay for routine exams.</p>	<p><b>IN-NETWORK</b> \$0 copay for routine exams Limited to 1 exam(s) every year.</p> <p><b>OUT-OF-NETWORK</b> \$25 copay for routine exams.</p>
<p><b>IN-NETWORK</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"><li>• Additional Smoking Cessation</li><li>• Nursing Hotline</li><li>• \$0 copay for each Medicare-covered smoking cessation counseling session.</li><li>• \$0 copay for each Medicare-covered HIV Screening</li></ul> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for Health and Wellness services.</p>	<p><b>IN-NETWORK</b> The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"><li>• Additional Smoking Cessation</li><li>• Nursing Hotline</li><li>• \$0 copay for each Medicare-covered smoking cessation counseling session.</li><li>• \$0 copay for each Medicare-covered HIV Screening</li></ul> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p><b>OUT-OF-NETWORK</b> \$0 copay for Health and Wellness services.</p>
<p><b>IN-NETWORK</b> This plan does not cover routine transportation.</p>	<p><b>IN-NETWORK</b> This plan does not cover routine transportation.</p>

## Section II: Summary of Benefits

BENEFIT	ORIGINAL MEDICARE
<b>Acupuncture</b>	Not covered.
<b>Optional Supplemental Package #1</b>	
<b>Premium and Other Important Information</b> <b>Dental Services</b>	

## CLEAR CARE PRESTIGE PPO

### IN-NETWORK

This plan does not cover Acupuncture.

## CLEAR CARE ELITE PPO

### IN-NETWORK

This plan does not cover Acupuncture.

### GENERAL

#### Package: 1 Clear Care Dental:

\$49 monthly premium, in addition to your \$71 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Preventive Dental
- Comprehensive Dental

\$1,500 plan coverage limit every year for these benefits.

### IN-NETWORK

\$0 copay for the following preventive dental benefits:

- up to 1 oral exam(s) every six months
- up to 1 cleaning(s) every six months
- up to 1 fluoride treatment(s) every six months
- up to 1 dental x-ray(s) every six months

### OUT-OF-NETWORK

- 20% of the cost for preventive dental services.
- 30% to 60% of the cost for comprehensive dental services.

### IN AND OUT-OF-NETWORK

\$1,500 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.

Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.

### GENERAL

#### Package: 1 Clear Care Dental:

\$49 monthly premium, in addition to your \$109 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:

- Preventive Dental
- Comprehensive Dental

\$1,500 plan coverage limit every year for these benefits.

### IN-NETWORK

\$0 copay for the following preventive dental benefits:

- up to 1 oral exam(s) every six months
- up to 1 cleaning(s) every six months
- up to 1 fluoride treatment(s) every six months
- up to 1 dental x-ray(s) every six months

### OUT-OF-NETWORK

- 20% of the cost for preventive dental services.
- 30% to 60% of the cost for comprehensive dental services.

### IN AND OUT-OF-NETWORK

\$1,500 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.

Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.





## Clear Care PPO Service area zip codes

98362	98358	99338	99353	99343	98923	98932	98939	98901	98907
98363	98368	99345	99354	99301	98904	98933	98942	98903	98908
98382	99320	99346	99326	99302	98929	98935	98944	98951	98909
98325	99336	99350	99330	98920	98937	98936	98947	98952	98953
98339	99337	99352	99335	98921	98930	98938	98948	98902	

Group Health Options, Inc. Clear Care PPO plans are preferred provider plans with a Medicare Advantage (MA) contract. Applicants must have Parts A and B Medicare coverage. Group Health's CMS contract is renewed annually; therefore, our contract with CMS may not renew, resulting in the termination of coverage with Group Health. If you enroll in a MA or MAPD plan you may not enroll in a stand-alone Part D prescription drug plan unless you disenroll from your MA plan. You must continue to pay your Medicare Part B premiums. With the exception of emergencies or urgent care, it may cost more to get care from out-of-network providers.

The benefit information herein is a brief Summary, not a comprehensive description of benefits. Limitations, copayments, and restrictions may apply. Applicants may enroll in the plans only during specific times of the year. For more information contact the plan. Benefits, formulary, pharmacy network, premium and/or copayments may change on 01/01/2012. You must use network pharmacies to access prescription drug benefit, except in non-routine circumstances, and quantity limitations and restrictions may apply.

This information is available in alternative languages or formats. For information, please call 1-800-446-8882 or TTY WA Relay at 1-800-833-6388 or 711. Call Monday–Friday from 8 a.m. to 8 p.m. From November 15 through March 1, call daily from 8 a.m. to 8 p.m.

Esta información también está disponible en otros idiomas o formatos. Para mayor información favor de llamar al 1-800-446-8882 o TTY (teléfono de texto) Centro de Relevo WA al 1-800-833-6388 o 711, de lunes a viernes de las 8:00 a las 20:00 horas. Del 15 de noviembre hasta el 1 de marzo con horario todos los días de las 8:00 a las 20:00 horas.



[www.ghc.org](http://www.ghc.org)  
1-800-446-8882