

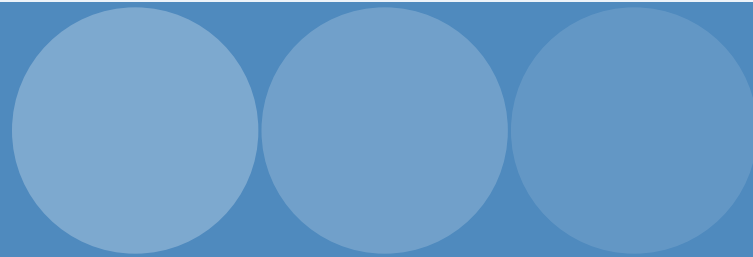
Summary of Benefits

Group Health Cooperative Clear Care® Sound (HMO SNP)

BENEFITS EFFECTIVE:

JANUARY 1, 2012– DECEMBER 31, 2012

H5050



Introduction to the Summary of Benefits Report

for **GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)**
January 1, 2012–December 31, 2012
KING/PIERCE

Thank you for your interest in Group Health Cooperative Clear Care Sound (HMO SNP). Our plan is offered by GROUP HEALTH COOPERATIVE, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria. If you have been diagnosed with Diabetes mellitus you may be eligible to join this plan.

Please call Group Health Cooperative Clear Care Sound (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Group Health Cooperative Clear Care Sound (HMO SNP) 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 Cooperative Clear Care Sound (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have one or more of the listed diseases you may enroll in the plan at any time but you may only leave the plan at certain times.

Please call Group Health Cooperative Clear Care Sound (HMO SNP) 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 Cooperative Clear Care Sound (HMO SNP) 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 IS GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP) AVAILABLE?

The service area for this plan includes: King, and Pierce Counties, WA. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)?

You can join Group Health Cooperative Clear Care Sound (HMO SNP) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

Introduction to the Summary of Benefits Report

for GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)

January 1, 2012–December 31, 2012

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However, individuals with End-Stage Renal Disease generally are not eligible to enroll in Group Health Cooperative Clear Care Sound (HMO SNP) unless they are members of our organization and have been since their dialysis began. You must have been diagnosed by your doctor with Diabetes mellitus to join this plan.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

Group Health Cooperative Clear Care Sound (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at www.ghc.org/medicare. 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?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Group Health Cooperative Clear Care Sound (HMO SNP) has 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. 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 Cooperative Clear Care Sound (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Group Health Cooperative Clear Care Sound (HMO SNP) uses 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.

Introduction to the Summary of Benefits Report

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January 1, 2012–December 31, 2012
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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** '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 THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, 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.

Introduction to the Summary of Benefits Report

for **GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)**

January 1, 2012–December 31, 2012

KING/PIERCE

As a member of Group Health Cooperative Clear Care Sound (HMO SNP), 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 Group Health Cooperative Clear Care Sound (HMO SNP), 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 the 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.

Introduction to the Summary of Benefits Report

for **GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)**
January 1, 2012–December 31, 2012
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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 Cooperative Clear Care Sound (HMO SNP) 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 Cooperative Clear Care Sound (HMO SNP) 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** administered through DME.

Introduction to the Summary of Benefits Report

for **GROUP HEALTH COOPERATIVE CLEAR CARE SOUND (HMO SNP)**
January 1, 2012–December 31, 2012
KING/PIERCE

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 “Health and Drug Plans” then “Compare Drug and Health Plans” 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 below.

Please call Group Health Cooperative for more information about Group Health Cooperative Clear Care Sound (HMO SNP). 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.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category

Original Medicare

Group Health Cooperative
Clear Care Sound (HMO SNP)

IMPORTANT INFORMATION

1–Premium and Other Important Information

In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.

If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.

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 **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**.

General

\$115 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 higher Part B and Part D premiums 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**.

In-Network

\$2,500 out-of-pocket limit for Medicare-covered services.

2–Doctor and Hospital Choice (For more information, see Emergency Care–#15 and Urgently Needed Care–#16.)

You may go to any doctor, specialist or hospital that accepts Medicare.

In-Network

You must go to network doctors, specialists, and hospitals.

Referral required for network hospitals and specialists (for certain benefits).

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
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SUMMARY OF BENEFITS

INPATIENT CARE

3–Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)

In 2011 the amounts for each benefit period were:
 Days 1–60: \$1132 deductible
 Days 61–90: \$283 per day
 Days 91–150: \$566 per lifetime reserve day

These amounts may change for 2012. Call **1-800-MEDICARE (1-800-633-4227)** for information about lifetime reserve days. Lifetime reserve days can only be used once.

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.

In-Network
 No limit to the number of days covered by the plan each hospital stay.

For Medicare-covered hospital stays:
 Days 1–5: \$100 copay per day
 Days 6–90: \$0 copay per day
 \$0 copay for additional hospital days

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

4–Inpatient Mental Health Care

In 2011 the amounts for each benefit period were:
 Days 1–60: \$1132 deductible
 Days 61–90: \$283 per day
 Days 91–150: \$566 per lifetime reserve day

These amounts may change for 2012. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

In-Network
 You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.

For Medicare-covered hospital stays:
 Days 1–5: \$100 copay per day
 Days 6–90: \$0 copay per day

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

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
<p>5–Skilled Nursing Facility (SNF) (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 were:</p> <p>Days 1–20: \$0 per day Days 21–100: \$141.50 per day</p> <p>These amounts may change for 2012. 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>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1–10: \$0 copay per day Days 11–100: \$25 copay per day</p>
<p>6–Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p>
<p>7–Hospice</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>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
OUTPATIENT CARE		
8–Doctor Office Visits	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 copay for each in-area, network urgent care Medicare-covered visit \$25 copay for each specialist visit for Medicare-covered benefits.</p>
9–Chiropractic Services	Supplemental routine care not covered 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>In-Network \$10 copay for each Medicare-covered visit 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>
10–Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered visit \$25 copay for up to 12 supplemental routine visit(s) every year Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
11–Outpatient Mental Health Care	<p>40% coinsurance for most outpatient mental health services</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>“Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each Medicare-covered individual therapy visit \$10 copay for each Medicare-covered group therapy visit \$10 copay for each Medicare-covered individual therapy visit with a psychiatrist \$10 copay for each Medicare-covered group therapy visit with a psychiatrist \$0 copay for Medicare-covered partial hospitalization program services</p>
12–Outpatient Substance Abuse Care	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered individual visits \$10 copay for Medicare-covered group visits</p>
13–Outpatient Services/ Surgery	<p>20% coinsurance for the doctor’s services</p> <p>Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare-covered ambulatory surgical center visit \$200 copay for each Medicare-covered outpatient hospital facility visit</p>
14–Ambulance Services (medically necessary ambulance services)	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$150 copay for Medicare-covered ambulance benefits.</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
15–Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor’s services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don’t have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	General \$65 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.
16–Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General \$10 copay for Medicare-covered urgently-needed-care visits
17–Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network \$10 copay for Medicare-covered Occupational Therapy visits \$10 copay for Medicare-covered Physical and/or Speech and Language Therapy visits

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

18 –Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items
19–Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
20–Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	In-Network \$0 copay for Diabetes self-management training \$0 copay for: <ul style="list-style-type: none"> • Diabetes monitoring supplies • Therapeutic shoes or inserts
21–Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays \$0 copay for Medicare-covered lab services 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 supplemental routine screening tests, like checking your cholesterol. 20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered: <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests \$0 copay for Medicare-covered X-rays \$40 copay for Medicare-covered diagnostic radiology services (not including X-rays) \$0 copay for Medicare-covered therapeutic radiology services
22–Cardiac and Pulmonary Rehabilitation Services	20% coinsurance Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments.	General Authorization rules may apply. In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services \$10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services \$10 copay for Medicare-covered Pulmonary Rehabilitation Services

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
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PREVENTIVE SERVICES

23–Preventive Services and Wellness/Education Programs

No coinsurance, copayment or deductible for the following:

- Abdominal Aortic Aneurysm Screening
- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine for people with Medicare who are at risk
- HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. 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.
- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.

General

\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:

- Abdominal Aortic Aneurysm screening
- Bone Mass Measurement
- Cardiovascular Screening
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)
- Colorectal Cancer Screening
- Diabetes Screening
- Influenza Vaccine
- Hepatitis B Vaccine
- HIV Screening
- Breast Cancer Screening (Mammogram)
- Medical Nutrition Therapy Services
- Personalized Prevention Plan Services (Annual Wellness Visits)
- Pneumococcal Vaccine
- Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)
- Smoking Cessation (Counseling to stop smoking)
- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
	<ul style="list-style-type: none"> • Medical Nutrition Therapy Services 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	<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. Please contact plan for details.</p> <p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Additional Smoking Cessation • Health Club Membership/ Fitness Classes • Nursing Hotline
<p>24-Kidney Disease and Conditions</p>	<p>20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services</p>	<p>In-Network \$0 copay for renal dialysis \$0 copay for kidney disease education services</p>

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
<p>25–Outpatient Prescription Drugs</p>	<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>	<p>Drugs covered under Medicare Part B</p> <p>General \$0 copay for Part B-covered drugs.</p> <p>Home Infusion Drugs, Supplies and Services</p> <p>General \$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.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ghc.org/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/about PartDFormulary.html on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>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.</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Group Health Cooperative Clear Care Sound (HMO SNP) for certain drugs.</p> <p>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.</p> <p>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.</p> <p>If you request a formulary exception for a drug and Group Health Cooperative Clear Care Sound (HMO SNP) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (30-day) supply of drugs in this tier • \$12 copay for a three-month (90-day) supply of drugs in this tier

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$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 <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$16 copay for a one-month (30-day) supply of drugs in this tier • \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • 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 <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$15 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$16 copay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (31-day) supply of drugs in this tier

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none">• \$4 copay for a one-month (30-day) supply of drugs in this tier• \$12 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none">• \$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 <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none">• \$16 copay for a one-month (30-day) supply of drugs in this tier• \$48 copay for a three-month (90-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none">• 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 <p>Additional Coverage Gap You pay the following:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none">• \$4 copay for a one-month (30-day) supply of all drugs covered in this tier• \$12 copay for a three-month (90-day) supply of all drugs covered in this tier <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none">• \$4 copay for a one-month (31-day) supply of all drugs covered in this tier

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (30-day) supply of all drugs covered in this tier • \$12 copay for a three-month (90-day) supply of all drugs covered in this tier <p>After your total yearly drug costs reach \$2,930, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 86% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>Out-of-Network</p> <p>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 Cooperative Clear Care Sound (HMO SNP).</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>Out-of-Network Initial Coverage You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$15 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> • \$16 copay for a one-month (30-day) supply of drugs in this tier <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Additional Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> • \$4 copay for a one-month (30-day) supply of all drugs covered in this tier <p>Tier 2: Non-Preferred Generic Drugs</p> <ul style="list-style-type: none"> • You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
		<p>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 \$4,700.</p> <p>Tier 3: Preferred Brand Drugs</p> <ul style="list-style-type: none"> You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>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 \$4,700.</p> <p>Tier 4: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700. <p>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 \$4,700.</p> <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> 5% coinsurance, or \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category	Original Medicare	Group Health Cooperative Clear Care Sound (HMO SNP)
26–Dental Services	Preventive dental services (such as cleaning) not covered.	<p>General Authorization rules may apply.</p> <p>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</p>
27–Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	<p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> • \$10 copay for Medicare-covered diagnostic hearing exams • \$10 copay for up to 1 supplemental routine hearing exams(s) every year
28–Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental 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.	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> • one pair of eyeglasses or contact lenses after cataract surgery • \$10 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye. • \$0 copay for up to 1 supplemental routine eye exam(s) every year
Over-the-Counter Items	Not covered.	<p>General The plan does not cover Over-the-Counter items.</p>
Transportation (Routine)	Not covered.	<p>In-Network This plan does not cover supplemental routine transportation.</p>
Acupuncture	Not covered.	<p>In-Network This plan does not cover Acupuncture.</p>

Summary of Benefits Report for Contract H5050, Plan 012

Benefit Category

Original Medicare

Group Health Cooperative
Clear Care Sound (HMO SNP)

OPTIONAL SUPPLEMENTAL PACKAGE #1

Premium and Other Important Information

General

Package: 1-Clear Care Dental:

\$49 monthly premium, in addition to your \$115 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.

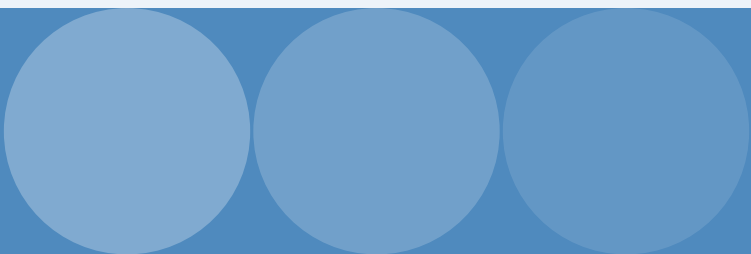
General

Plan offers additional comprehensive dental benefits.

In-Network

- 0% to 20% of the cost for up to 2 cleaning(s) every year
- 0% to 20% of the cost for up to 2 fluoride treatment(s) every year
- 0% to 20% of the cost for up to 2 oral exam(s) every year
- 0% to 20% of the cost for up to 2 dental x-ray(s) every year

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



Customer Service

1-888-901-4600

TTY WA Relay:

1-800-833-6388 or 711

Monday–Friday, 8 a.m.–8 p.m.

Extended hours

October 15–February 14

Daily 8 a.m.–8 p.m.



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