

## SUMMARY OF BENEFITS

Clear Care Vital (HMO)

Clear Care Basic (HMO)

Clear Care Essential (HMO)

Clear Care Optimal (HMO)

## BENEFITS EFFECTIVE:

JAN 1, 2010 – DEC 31, 2010

## COUNTIES SERVED:

Island, King, Kitsap, Lewis,  
Pierce, San Juan, Skagit,  
Snohomish, Spokane,  
Thurston, Whatcom,  
and parts of Mason  
and Grays Harbor

H5050



# Section I: Introduction to summary of benefits

## Thank you for your interest in Group Health's Clear Care Vital (HMO), Clear Care Basic (HMO), Clear Care Essential (HMO), and Clear Care Optimal (HMO) plans.

Our plans are offered by Group Health Cooperative, a Medicare Advantage Health Maintenance Organization (HMO). This summary of benefits tells you some features of our plan. 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 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's Clear Care 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 join or leave a plan only at certain times. Please call Group Health Customer Service at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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's Clear Care 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 additional benefits, which may change from year to year.

## Where are the Clear Care plans available?

There is more than one plan listed in this summary of benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

The service area for these plans include the following counties in Washington: Grays Harbor (partial), Island, King, Kitsap, Lewis, Mason (partial), Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom. You must live in one of these areas to join one of these plans. Please see the back cover of this brochure for a list of all the Clear Care HMO service area zip codes.

## Who is eligible to join a Clear Care plan?

You can join a Clear Care plan 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 not generally eligible to enroll in a Clear Care plan unless they are members of our organization and have been since their dialysis began.

## Can I choose my doctors?

Group Health Cooperative 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 or, for an up-to-date list, visit us at [www.ghc.org/medicare](http://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. Neither Group Health Cooperative nor the Original Medicare Plan will pay for these services.

## Does my plan cover Medicare Part B or Part D drugs?

Clear Care plans do cover Medicare Part B prescription drugs. And we offer three plans with Part D prescription drug coverage: Clear Care Vital, Clear Care Essential, and Clear Care Optimal.

## Where can I get my prescription if I am enrolled in or choose the Clear Care Vital, Clear Care Essential, or the Clear Care Optimal plan?

Group Health Cooperative 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 current pharmacy network list or visit us at [www.ghc.org](http://www.ghc.org) by clicking on Pharmacy Services.

## What is a prescription drug formulary?

Group Health Cooperative 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](http://www.ghc.org) by clicking on Pharmacy Services.

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 prescription drug plan costs?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call: 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week. Or you can call 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 call your state Medicaid office.

## What are my protections on the Clear Care Vital, Clear Care Essential, and Clear Care Optimal 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 plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

# Section I: Introduction to summary of benefits

As a member of a Clear Care Vital (HMO), Clear Care Essential (HMO), or Clear Care Optimal (HMO) 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 for your state, Qualis Health at 1-800-949-7536.

As a member of a Clear Care Vital, Clear Care Essential or Clear Care Optimal plan, 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 nonpreferred 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 for your state, Qualis Health at 1-800-949-7536.

## What is the Medication Therapy Management Program?

A Medication Therapy Management (MTM) Program is a free service we may offer through the Clear Care Vital, Clear Care Essential, and Clear Care Optimal plans. 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's Customer Service department 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 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 alpha 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.

## 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](http://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 at 1-888-901-4600 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-833-6388.

Please contact Customer Service for more information about the Clear Care Vital, Clear Care Basic, Clear Care Essential, or the Clear Care Optimal plan. Visit us at [www.ghc.org/medicare](http://www.ghc.org/medicare) or call us:

## CUSTOMER SERVICE HOURS

Monday–Friday, 8 a.m.–8 p.m. Pacific

## November 15–February 28

Daily 8 a.m.–8 p.m. Pacific

## CURRENT MEMBERS

Call 1-888-901-4600 for questions related to the Medicare Advantage program and the Medicare Part D Prescription Drug program (TTY/TDD 1-800-833-6388).

## PROSPECTIVE MEMBERS

Call 1-800-446-8882 for questions related to the Medicare Advantage program and the Medicare Part D Prescription Drug program Monday through Friday 8 a.m.–5 p.m. November 15, 2009–February 28, 2010, daily 8 a.m.–8 p.m. (TTY/TDD 1-800-833-6388).

## FOR MORE INFORMATION ABOUT MEDICARE

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](http://www.medicare.gov) on the Web.

Group Health Cooperative has a Medicare Advantage contract with the Centers for Medicare and Medicaid Services (CMS), the branch of the federal government that administers Medicare. This contract is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed. Applicants must have Parts A and B Medicare coverage. Enrolled members must use Group Health providers for routine care. If you have special needs, this document may be available in other formats.

# Section II: Summary of benefits

## Important information

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>1 Premium and Other Important Information</b>	<p>In 2009 the monthly Part B premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>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, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>GENERAL</b> \$17 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p><b>IN-NETWORK</b> \$3,200 out-of-pocket limit</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Dental Services</li> <li>• Hearing Services</li> <li>• Vision Services</li> </ul>	<p><b>GENERAL</b> \$17 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p><b>IN-NETWORK</b> \$2,500 out-of-pocket limit</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Dental Services</li> <li>• Hearing Services</li> <li>• Vision Services</li> </ul>	<p><b>GENERAL</b> \$116 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p><b>IN-NETWORK</b> \$2,500 out-of-pocket limit</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Dental Services</li> <li>• Hearing Services</li> <li>• Vision Services</li> </ul>	<p><b>GENERAL</b> \$208 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p><b>IN-NETWORK</b> \$1,000 out-of-pocket limit</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> <li>• Dental Services</li> <li>• Hearing Services</li> <li>• Vision Services</li> </ul>
<b>2 Doctor and Hospital Choice</b> (For more information, see <a href="#">Emergency—#15</a> and <a href="#">Urgently Needed Care—#16</a> )	<p>You may go to any doctor, specialist, or hospital that accepts Medicare</p>	<p><b>IN-NETWORK</b> You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>OUT-OF-NETWORK</b> Plan covers you when you travel in the U.S.</p>	<p><b>IN-NETWORK</b> You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>OUT-OF-NETWORK</b> Plan covers you when you travel in the U.S.</p>	<p><b>IN-NETWORK</b> You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>OUT-OF-NETWORK</b> Plan covers you when you travel in the U.S.</p>	<p><b>IN-NETWORK</b> You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p><b>OUT-OF-NETWORK</b> Plan covers you when you travel in the U.S.</p>

# Section II: Summary of benefits

## Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<p><b>3 Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$1068 deductible</li> <li>• Days 61–90: \$267 per day</li> <li>• Days 91–150: \$534 per lifetime reserve day</li> </ul> <p>These amounts will change for 2010.</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–3: \$350 copay per day</li> <li>• Days 4–90: \$0 copay per day</li> <li>• \$0 copay for additional hospital days</li> </ul> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–5: \$200 copay per day</li> <li>• Days 6–90: \$0 copay per day</li> <li>• \$0 copay for additional hospital days</li> </ul> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–5: \$200 copay per day</li> <li>• Days 6–90: \$0 copay per day</li> <li>• \$0 copay for additional hospital days</li> </ul> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–3: \$100 copay per day</li> <li>• Days 4–90: \$0 copay per day</li> <li>• \$0 copay for additional hospital days</li> </ul> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p><b>4 Inpatient Mental Health Care</b></p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190-day lifetime limit in a Psychiatric Hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–3: \$350 copay per day</li> <li>• Days 4–90: \$0 copay per day</li> </ul> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–5: \$200 copay per day</li> <li>• Days 6–90: \$0 copay per day</li> </ul> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–5: \$200 copay per day</li> <li>• Days 6–90: \$0 copay per day</li> </ul> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p><b>IN-NETWORK</b></p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> <li>• Days 1–3: \$100 copay per day</li> <li>• Days 4–90: \$0 copay per day</li> </ul> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

# Section II: Summary of benefits

## Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<p><b>5 Skilled Nursing Facility (SNF)</b> (in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <ul style="list-style-type: none"> <li>Days 1–20: \$0 per day</li> <li>Days 21–100: \$133.50 per day</li> </ul> <p>These amounts will change for 2010.</p> <ul style="list-style-type: none"> <li>100 days for each benefit period</li> </ul> <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>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> For SNF stays:</p> <ul style="list-style-type: none"> <li>Days 1–100: \$75 copay per day</li> <li>Plan covers up to 100 days for each benefit period.</li> <li>No prior hospital stay is required.</li> </ul>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> For SNF stays:</p> <ul style="list-style-type: none"> <li>Days 1–10: \$0 copay per day</li> <li>Days 11–100: \$60 copay per day</li> <li>Plan covers up to 100 days for each benefit period.</li> <li>No prior hospital stay is required.</li> </ul>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> For SNF stays:</p> <ul style="list-style-type: none"> <li>Days 1–10: \$0 copay per day</li> <li>Days 11–100: \$50 copay per day</li> <li>Plan covers up to 100 days for each benefit period.</li> <li>No prior hospital stay is required.</li> </ul>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> For SNF stays:</p> <ul style="list-style-type: none"> <li>Days 1–10: \$0 copay per day</li> <li>Days 11–100: \$25 copay per day</li> <li>Days 101–150: \$25 copay per day</li> <li>Plan covers up to 150 days for each benefit period.</li> <li>No prior hospital stay is required.</li> </ul>
<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>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$0 copay for Medicare-covered home health visits</p>
<p><b>7 Hospice</b></p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>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> 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> You must get care from a Medicare-certified hospice.</p>

# Section II: Summary of benefits

## Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>8 Doctor Office Visits</b>	20% coinsurance	<p><b>GENERAL</b> See "Physical Exams" for more information. Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$30 copay for each primary care doctor visit for Medicare-covered benefits \$30 copay for each in-area network urgent care Medicare-covered visit \$30 copay for each specialist visit for Medicare-covered benefits</p>	<p><b>GENERAL</b> See "Physical Exams" for more information. Authorization rules may apply.</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 \$20 copay for each specialist visit for Medicare-covered benefits</p>	<p><b>GENERAL</b> See "Physical Exams" for more information. Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$15 copay for each primary care doctor visit for Medicare-covered benefits \$15 copay for each in-area network urgent care Medicare-covered visit \$15 copay for each specialist visit for Medicare-covered benefits</p>	<p><b>GENERAL</b> See "Physical Exams" for more information. Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$15 copay for each primary care doctor visit for Medicare-covered benefits \$15 copay for each in-area network urgent care Medicare-covered visit \$15 copay for each specialist visit for Medicare-covered benefits</p>
<b>9 Chiropractic Services</b>	<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 provider.</p>	<p><b>IN-NETWORK</b> \$30 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>	<p><b>IN-NETWORK</b> \$20 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>	<p><b>IN-NETWORK</b> \$15 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>	<p><b>IN-NETWORK</b> \$15 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>
<b>10 Podiatry Services</b>	<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>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$30 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$20 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$15 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p><b>GENERAL</b> Authorization rules may apply.</p> <p><b>IN-NETWORK</b> \$15 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care.</p>

# Section II: Summary of benefits

## Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>11 Outpatient Mental Health Care</b>	45% coinsurance for most outpatient mental health services	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$30 copay for each Medicare-covered individual or group therapy visit	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$20 copay for each Medicare-covered individual or group therapy visit	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$15 copay for each Medicare-covered individual or group therapy visit.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$15 copay for each Medicare-covered individual or group therapy visit
<b>12 Outpatient Substance Abuse Care</b>	20% coinsurance	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$30 copay for Medicare-covered individual or group visits	<b>IN-NETWORK</b> \$20 copay for Medicare-covered individual or group visits	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$15 copay for Medicare-covered individual or group visits	<b>IN-NETWORK</b> \$15 copay for Medicare-covered individual or group visits
<b>13 Outpatient Services/ Surgery</b>	20% coinsurance for the doctor 20% of outpatient facility charges	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$300 copay for each Medicare-covered ambulatory surgical center visit  \$300 copay for each Medicare-covered outpatient hospital facility visit	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$200 copay for each Medicare-covered ambulatory surgical center visit  \$200 copay for each Medicare-covered outpatient hospital facility visit	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$200 copay for each Medicare-covered ambulatory surgical center visit  \$200 copay for each Medicare-covered outpatient hospital facility visit	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$100 copay for each Medicare-covered ambulatory surgical center visit  \$100 copay for each Medicare-covered outpatient hospital facility visit
<b>14 Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$200 copay for Medicare-covered ambulance benefits	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$150 copay for Medicare-covered ambulance benefits	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$150 copay for Medicare-covered ambulance benefits	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$75 copay for Medicare-covered ambulance benefits

# Section II: Summary of benefits

## Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>15 Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit 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. NOT covered outside the U.S. except under limited circumstances	<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.	<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.	<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.	<b>IN-NETWORK</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.
<b>16 Urgently Needed Care</b> (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	<b>GENERAL</b> \$30 copay for Medicare-covered urgently needed care visits	<b>GENERAL</b> \$20 copay for Medicare-covered urgently needed care visits	<b>GENERAL</b> \$15 copay for Medicare-covered urgently needed care visits	<b>GENERAL</b> \$15 copay for Medicare-covered urgently needed care visits
<b>17 Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$30 copay for Medicare-covered Occupational Therapy visits \$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$20 copay for Medicare-covered Occupational Therapy visits \$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$15 copay for Medicare-covered Occupational Therapy visits \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$15 copay for Medicare-covered Occupational Therapy visits \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits

# Section II: Summary of benefits

## Outpatient medical services and supplies

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>18 Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	20% coinsurance	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items
<b>19 Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> 20% of the cost for Medicare-covered items
<b>20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	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 registered dietitians or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for diabetes self-monitoring training  \$0 copay for nutrition therapy for diabetes  20% of the cost for diabetes supplies	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for diabetes self-monitoring training  \$0 copay for nutrition therapy for diabetes  20% of the cost for diabetes supplies	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for diabetes self-monitoring training  \$0 copay for nutrition therapy for diabetes  20% of the cost for diabetes supplies	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for diabetes self-monitoring training  \$0 copay for nutrition therapy for diabetes  20% of the cost for diabetes supplies
<b>21 Diagnostic Tests, X-rays, Lab Services, and Radiology Services</b>	20% coinsurance for diagnostic tests and X-rays  \$0 copay for Medicare-covered lab services  <b>Lab Services:</b> 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.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> <ul style="list-style-type: none"> <li>\$0 copay for Medicare-covered:                             <ul style="list-style-type: none"> <li>lab services</li> <li>diagnostic procedures and tests</li> </ul> </li> <li>\$0 copay for Medicare-covered X-rays</li> <li>\$150 copay for Medicare-covered diagnostic radiology services</li> <li>\$0 copay for Medicare-covered therapeutic radiology services</li> </ul>	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> <ul style="list-style-type: none"> <li>\$0 copay for Medicare-covered:                             <ul style="list-style-type: none"> <li>lab services</li> <li>diagnostic procedures and tests</li> </ul> </li> <li>\$0 copay for Medicare-covered X-rays</li> <li>\$75 copay for Medicare-covered diagnostic radiology services</li> <li>\$0 copay for Medicare-covered therapeutic radiology services</li> </ul>	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> <ul style="list-style-type: none"> <li>\$0 copay for Medicare-covered:                             <ul style="list-style-type: none"> <li>lab services</li> <li>diagnostic procedures and tests</li> </ul> </li> <li>\$0 copay for Medicare-covered X-rays</li> <li>\$50 copay for Medicare-covered diagnostic radiology services</li> <li>\$0 copay for Medicare-covered therapeutic radiology services</li> </ul>	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> <ul style="list-style-type: none"> <li>\$0 copay for Medicare-covered:                             <ul style="list-style-type: none"> <li>lab services</li> <li>diagnostic procedures and tests</li> </ul> </li> <li>\$0 copay for Medicare-covered X-rays</li> <li>\$40 copay for Medicare-covered diagnostic radiology services</li> <li>\$0 copay for Medicare-covered therapeutic radiology services</li> </ul>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>22 Bone Mass Measurement</b> (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered bone mass measurement
<b>23 Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered colorectal screenings
<b>24 Immunizations</b> (Flu vaccine, hepatitis B vaccine—for people with Medicare who are at risk, pneumonia vaccine)	\$0 copay for flu and pneumonia vaccines 20% coinsurance for hepatitis B vaccine You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information.	<b>GENERAL</b> Authorization rules may apply.  <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 Referral needed for other immunizations	<b>GENERAL</b> Authorization rules may apply.  <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 Referral needed for other immunizations	<b>GENERAL</b> Authorization rules may apply.  <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 Referral needed for other immunizations	<b>GENERAL</b> Authorization rules may apply.  <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 Referral needed for other immunizations
<b>25 Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)	20% coinsurance No referral needed 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.	<b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms	<b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms	<b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms	<b>IN-NETWORK</b> \$0 copay for Medicare-covered screening mammograms

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>26 Pap Smears and Pelvic Exams</b> (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years Covered once a year for women with Medicare at high risk 20% coinsurance for pelvic exams	<b>IN-NETWORK</b> \$0 copay for Medicare-covered Pap smears and pelvic exams	<b>IN-NETWORK</b> \$0 copay for Medicare-covered Pap smears and pelvic exams	<b>IN-NETWORK</b> \$0 copay for Medicare-covered Pap smears and pelvic exams	<b>IN-NETWORK</b> \$0 copay for Medicare-covered Pap smears and pelvic exams
<b>27 Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam \$0 for the PSA test; 20% coinsurance for other related services Covered once a year for all men with Medicare over age 50	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for Medicare-covered prostate cancer screening
<b>28 End Stage Renal Disease</b>	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End Stage Renal Disease 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 registered dietitians or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for nutrition therapy for End Stage Renal Disease	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for nutrition therapy for End Stage Renal Disease	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for nutrition therapy for End Stage Renal Disease	<b>GENERAL</b> Authorization rules may apply.  <b>IN-NETWORK</b> \$0 copay for renal dialysis \$0 copay for nutrition therapy for End Stage Renal Disease

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>29 Prescription Drugs</b>	<p>Most drugs are not covered by 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><b>Drugs covered under Medicare Part B</b> GENERAL \$0 copay for Part B covered drugs.</p> <p><b>Drugs covered under Medicare Part C</b> 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><b>Drugs covered under Medicare Part D</b> GENERAL This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.ghc.org">www.ghc.org</a> by clicking on Pharmacy Services. 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.</p>	<p><b>Drugs covered under Medicare Part B</b> GENERAL \$0 copay for Part B covered drugs</p> <p><b>Drugs covered under Medicare Part D</b> GENERAL This plan does not cover prescription drug coverage.</p> <p>GENERAL Most drugs not covered</p>	<p><b>Drugs covered under Medicare Part B</b> GENERAL \$0 copay for Part B covered drugs</p> <p><b>Drugs covered under Medicare Part C</b> 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><b>Drugs covered under Medicare Part D</b> GENERAL This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.ghc.org">www.ghc.org</a> by clicking on Pharmacy Services. 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.</p>	<p><b>Drugs covered under Medicare Part B</b> GENERAL \$0 copay for Part B covered drugs</p> <p><b>Drugs covered under Medicare Part C</b> 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><b>Drugs covered under Medicare Part D</b> GENERAL This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.ghc.org">www.ghc.org</a> by clicking on Pharmacy Services. 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.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<p><b>29 Prescription Drugs</b> <i>Continued</i></p>		<p>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> <p>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’s Clear Care Vital plan for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s Web site, formulary, and 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. If you request a tier exception in this plan, you will pay the nonpreferred cost share.</p>		<p>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> <p>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’s Clear Care Essential plan for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s Web site, formulary, and 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. If you request a tier exception in this plan, you will pay the nonpreferred cost share.</p>	<p>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> <p>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’s Clear Care Optimal plan for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan’s Web site, formulary, and 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. If you request a tier exception in this plan, you will pay the nonpreferred cost share.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>29 Prescription Drugs</b> <i>Continued</i> <b>IN-NETWORK</b>		<p><b>IN-NETWORK</b> \$310 yearly deductible</p> <p><b>INITIAL COVERAGE</b> After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:</p> <p><b>RETAIL PHARMACY</b> Preferred Generic</p> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$18 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$17 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$51 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 50% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>		<p><b>IN-NETWORK</b> \$310 yearly deductible</p> <p><b>INITIAL COVERAGE</b> After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:</p> <p><b>RETAIL PHARMACY</b> Preferred Generic</p> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$12 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$14 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$42 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 50% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p><b>IN-NETWORK</b> \$0 yearly deductible</p> <p><b>INITIAL COVERAGE</b> You pay the following until total yearly drug costs reach \$2,830:</p> <p><b>RETAIL PHARMACY</b> Preferred Generic</p> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$27 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$15 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$45 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>• 50% coinsurance for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>29 Prescription Drugs</b> <i>Continued</i>  <b>IN-NETWORK</b>		<b>LONG TERM CARE PHARMACY</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$17 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Nonpreferred</b> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>		<b>LONG TERM CARE PHARMACY</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$14 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Nonpreferred</b> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>	<b>LONG TERM CARE PHARMACY</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$15 copay for a one-month (31-day) supply of drugs in this tier</li> </ul> <b>Nonpreferred</b> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (31-day) supply of drugs in this tier</li> </ul>
		<b>MAIL ORDER</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$18 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$17 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$51 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>		<b>MAIL ORDER</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$12 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$14 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$42 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<b>MAIL ORDER</b> <b>Preferred Generic</b> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$27 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <b>Preferred Brand</b> <ul style="list-style-type: none"> <li>• \$15 copay for a one-month (30-day) supply of drugs in this tier</li> <li>• \$45 copay for a three-month (90-day) supply of drugs in this tier</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>29 Prescription Drugs</b> <i>Continued</i>  <b>IN-NETWORK</b>		<b>Mail order continued Nonpreferred</b> <ul style="list-style-type: none"> <li>50% coinsurance for a one month (30-day) supply of drugs in this tier</li> <li>50% coinsurance for a one month (90-day) supply of drugs in this tier</li> </ul> Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.		<b>Mail order continued Nonpreferred</b> <ul style="list-style-type: none"> <li>50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>50% coinsurance for a one-month (90-day) supply of drugs in this tier</li> </ul> Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.	<b>Mail order continued Nonpreferred</b> <ul style="list-style-type: none"> <li>50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> <li>50% coinsurance for a one-month (90-day) supply of drugs in this tier</li> </ul> Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.
			<b>COVERAGE GAP</b> After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.		<b>COVERAGE GAP</b> After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.
		<b>CATASTROPHIC COVERAGE</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: <ul style="list-style-type: none"> <li>\$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>5% coinsurance</li> </ul>		<b>CATASTROPHIC COVERAGE</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: <ul style="list-style-type: none"> <li>\$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>5% coinsurance</li> </ul>	<b>CATASTROPHIC COVERAGE</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: <ul style="list-style-type: none"> <li>\$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>5% coinsurance</li> </ul>
<b>OUT-OF-NETWORK</b>		<b>OUT-OF-NETWORK</b> 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 Clear Care Vital (HMO).		<b>OUT-OF-NETWORK</b> 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 Clear Care Essential (HMO).	<b>OUT-OF-NETWORK</b> 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 Clear Care Optimal (HMO).

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>29 Prescription Drugs</b> <i>Continued</i>  <b>OUT-OF-NETWORK</b>		<p><b>OUT-OF-NETWORK INITIAL COVERAGE</b></p> <p>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 \$2,830:</p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$17 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>		<p><b>OUT-OF-NETWORK INITIAL COVERAGE</b></p> <p>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 \$2,830:</p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>• \$4 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$14 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>	<p><b>OUT-OF-NETWORK INITIAL COVERAGE</b></p> <p>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 \$2,830:</p> <p><b>Preferred Generic</b></p> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Preferred Brand</b></p> <ul style="list-style-type: none"> <li>• \$15 copay for a one-month (30-day) supply of drugs in this tier</li> </ul> <p><b>Nonpreferred</b></p> <ul style="list-style-type: none"> <li>• 50% coinsurance for a one-month (30-day) supply of drugs in this tier</li> </ul>
			<p><b>OUT-OF-NETWORK COVERAGE GAP</b></p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Clear Care Vital for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>		<p><b>OUT-OF-NETWORK COVERAGE GAP</b></p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Clear Care Essential for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
		<p><b>OUT-OF-NETWORK CATASTROPHIC COVERAGE</b> 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 the following:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance</li> </ul>		<p><b>OUT-OF-NETWORK CATASTROPHIC COVERAGE</b> 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 the following:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance</li> </ul>	<p><b>OUT-OF-NETWORK CATASTROPHIC COVERAGE</b> 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 the following:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or</li> <li>• 5% coinsurance</li> </ul>
<b>30 Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<p><b>IN-NETWORK</b> In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits").</p> <p>0% of the cost for Medicare-covered dental benefits</p>	<p><b>IN-NETWORK</b> In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits").</p> <p>0% of the cost for Medicare-covered dental benefits</p>	<p><b>IN-NETWORK</b> In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits").</p> <p>0% of the cost for Medicare-covered dental benefits</p>	<p><b>IN-NETWORK</b> In general, preventive dental benefits (such as cleaning) are not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits").</p> <p>0% of the cost for Medicare-covered dental benefits</p>
<b>31 Hearing Services</b>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><b>IN-NETWORK</b> Hearing aids not covered</p> <ul style="list-style-type: none"> <li>• \$30 copay for Medicare covered diagnostic hearing exams</li> <li>• \$30 copay for up to 1 routine hearing test</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation</li> </ul>	<p><b>IN-NETWORK</b> Hearing aids not covered</p> <ul style="list-style-type: none"> <li>• \$20 copay for Medicare covered diagnostic hearing exams</li> <li>• \$20 copay for up to 1 routine hearing test</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation</li> </ul>	<p><b>IN-NETWORK</b> Hearing aids not covered</p> <ul style="list-style-type: none"> <li>• \$15 copay for Medicare covered diagnostic hearing exams</li> <li>• \$15 copay for up to 1 routine hearing test</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation</li> </ul>	<p><b>IN-NETWORK</b> \$0 copay for up to 1 hearing aid</p> <ul style="list-style-type: none"> <li>• \$15 copay for Medicare covered diagnostic hearing exams</li> <li>• \$15 copay for up to 1 routine hearing test</li> <li>• \$0 copay for up to 1 hearing aid fitting evaluation</li> </ul> <p>\$500 limit for hearing aids.</p>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>32 Vision Services</b>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye</p> <p>Routine eye exams and glasses not covered</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>Annual glaucoma screenings covered for people at risk</p>	<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• \$30 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$0 copay for up to 1 routine eye exam every year</li> </ul>	<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• \$20 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$0 copay for up to 1 routine eye exam every year</li> </ul>	<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• \$15 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$0 copay for up to 1 routine eye exam every year</li> </ul>	<p><b>IN-NETWORK</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</li> <li>• up to 1 pair of glasses</li> <li>• up to 1 pair of contacts</li> <li>• \$15 copay for exams to diagnose and treat diseases and conditions of the eye</li> <li>• \$0 copay for up to 1 routine eye exam every year</li> </ul> <p>\$150 limit for eye wear</p>
<b>33 Physical Exams</b>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>IN-NETWORK</b></p> <p>\$0 copay for routine exams</p> <p>Limited to 1 exam every year</p> <p>\$30 copay for Medicare-covered benefits</p>	<p><b>IN-NETWORK</b></p> <p>\$0 copay for routine exams</p> <p>Limited to 1 exam every year</p> <p>\$20 copay for Medicare-covered benefits</p>	<p><b>IN-NETWORK</b></p> <p>\$0 copay for routine exams</p> <p>Limited to 1 exam every year</p> <p>\$15 copay for Medicare-covered benefits</p>	<p><b>IN-NETWORK</b></p> <p>\$0 copay for routine exams</p> <p>Limited to 1 exam every year</p> <p>\$15 copay for Medicare-covered benefits</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.</p> <p>Each counseling attempt includes up to four face-to-face visits. You pay coinsurance and Part B deductible applies.</p>	<p><b>IN-NETWORK</b></p> <p>This plan covers health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional smoking cessation</li> <li>• Consulting Nurse Service</li> <li>• Health Club Membership/ Fitness Classes</li> <li>• \$0 copay for each Medicare-covered smoking cessation counseling session</li> </ul>	<p><b>IN-NETWORK</b></p> <p>This plan covers health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional smoking cessation</li> <li>• Consulting Nurse Service</li> <li>• Health Club Membership/ Fitness Classes</li> <li>• \$0 copay for each Medicare-covered smoking cessation counseling session</li> </ul>	<p><b>IN-NETWORK</b></p> <p>This plan covers health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional smoking cessation</li> <li>• Consulting Nurse Service</li> <li>• Health Club Membership/ Fitness Classes</li> <li>• \$0 copay for each Medicare-covered smoking cessation counseling session</li> </ul>	<p><b>IN-NETWORK</b></p> <p>This plan covers health/wellness education benefits:</p> <ul style="list-style-type: none"> <li>• Additional smoking cessation</li> <li>• Consulting Nurse Service</li> <li>• Health Club Membership/ Fitness Classes</li> <li>• Other Wellness Benefits</li> <li>• Copays may apply for these benefits</li> <li>• \$0 copay for each Medicare-covered smoking cessation counseling session</li> </ul>

# Section II: Summary of benefits

## Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE VITAL HMO	CLEAR CARE BASIC HMO	CLEAR CARE ESSENTIAL HMO	CLEAR CARE OPTIMAL HMO
<b>35 Transportation (Routine)</b>	Not covered	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$200 copay for one-way trips to plan-approved location	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$150 copay for one-way trips to plan-approved location	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$150 copay for one-way trips to plan-approved location	<b>GENERAL</b> Authorization rules may apply. <b>IN-NETWORK</b> \$75 copay for one-way trips to plan-approved location
<b>36 Acupuncture</b>	Not covered	<b>IN-NETWORK</b> This plan does not cover Acupuncture	<b>IN-NETWORK</b> This plan does not cover Acupuncture	<b>IN-NETWORK</b> This plan does not cover Acupuncture	<b>IN-NETWORK</b> This plan does not cover Acupuncture

## Optional supplemental package 1

<b>Premium and other important information</b> <b>Dental Services</b>		<b>GENERAL</b> Package 1: Dental \$48 monthly premium, in addition to your \$17 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services \$1,500 limit every year for these benefits <b>GENERAL</b> Plan offers additional comprehensive dental benefits <b>IN-NETWORK</b> \$0 copay for the following preventive dental benefits: • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 fluoride treatment every six months • Up to 1 dental X-ray every six months \$1500 limit for dental benefits every year	<b>GENERAL</b> Package 1: Dental \$48 monthly premium, in addition to your \$17 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services \$1,500 limit every year for these benefits <b>GENERAL</b> Plan offers additional comprehensive dental benefits <b>IN-NETWORK</b> \$0 copay for the following preventive dental benefits: • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 fluoride treatment every six months • Up to 1 dental X-ray every six months \$1500 limit for preventive dental benefits every year	<b>GENERAL</b> Package 1: Dental \$48 monthly premium, in addition to your \$116 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services \$1,500 limit every year for these benefits <b>GENERAL</b> Plan offers additional comprehensive dental benefits <b>IN-NETWORK</b> \$0 copay for the following preventive dental benefits: • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 fluoride treatment every six months • Up to 1 dental X-ray every six months \$1500 limit for preventive dental benefits every year	<b>GENERAL</b> Package 1: Dental \$48 monthly premium, in addition to your \$208 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services \$1,500 limit every year for these benefits <b>GENERAL</b> Plan offers additional comprehensive dental benefits <b>IN-NETWORK</b> \$0 copay for the following preventive dental benefits: • Up to 1 oral exam every six months • Up to 1 cleaning every six months • Up to 1 fluoride treatment every six months • Up to 1 dental X-ray every six months \$1500 limit for preventive dental benefits every year
--	--	--	---	--	--

# Section III: Other benefits

When you join a Clear Care plan you will also receive additional benefits as a Group Health member.

## YOU CAN

- Select from hundreds of personal physicians at Group Health medical centers statewide
- Select from hundreds of contracted personal physicians statewide
- Self-refer to hundreds of specialists at Group Health medical centers
- Change doctors anytime

## YOU'LL GET

- Use of the 24-hour Consulting Nurse helpline
- Thousands of health topics on our online library
- Health Profile, a secure Web-based health assessment tool
- Lifestyle Coaching, 24/7 telephone-based support from trained professionals, once you complete the Health Profile
- Usage status
- Online Rx refills with free home delivery

## Additional convenient services when using Group Health medical centers

- Secure e-mail access to your doctor
- Access to your online medical record and test results
- Online appointment scheduling
- Lab, pharmacy, and X-ray services at most Group Health medical centers
- Convenient appointment times, often same day

## OTHER PERKS

- Two fitness programs available, SilverSneakers® and EnhanceFitness®
- Access to the Travel Advisory Service
- Use the Group Health Resource Line
- Join the Senior Caucus
- Attend classes and events
- Clear Care travel benefit

## The Clear Care travel benefit

Non-emergent and/or non-urgently needed Medicare-covered care received while temporarily traveling outside Group Health's Medicare service area is payable at Medicare benefit levels up to \$3,000 per member per calendar year. Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services only. Member is responsible for all Medicare inpatient and outpatient deductibles and coinsurances.

## The Clear Care Optimal plan offers additional benefits that include:

- **12 self-referred alternative medicine visits each calendar year**

This means any combination of twelve visits for acupuncture, naturopathic medicine, and/or chiropractic manipulation for other than the spine. Office visit copays will apply. Note: You are already covered for spinal manipulation through your existing chiropractic benefit. Members must see plan contracted providers.

- **50 additional days of skilled nursing-facility care in addition to the 100 days of Medicare-covered skilled nursing facility care**

## Additional information about covered benefits found in Section II

### Dental Benefits

Note: If you have elected to purchase Dental Benefits, your monthly premium will be \$48 in addition to your plan premium each month. You are covered each year for a maximum of \$1,500 for **combined** Preventive and/or Comprehensive benefit for ALL plan covered dental services. Covered preventive services paid at 100% of Washington Dental Service (WDS) approved fee schedule. Restorative covered services paid at 80%

of WDS approved fee schedule. Coverage for denture adjustments and relines covered services paid at 80% of Washington Dental Service (WDS) approved fee schedule. A \$100 annual deductible applies to dental services except for preventive dental care.

### Skilled Nursing Facility (Group Health Covered)

When a 3-day Medicare covered hospital stay does not occur and the plan determines that the member otherwise meets all Medicare criteria for an acute inpatient hospital stay at the time of admission to a Medicare Certified Skilled Nursing Facility, the plan may authorize Medicare covered Skilled Nursing Facility Care up to the Medicare Skilled Nursing Facility day limit per benefit period. All Medicare criteria must be met and the stay must be authorized in advance by the plan.

### Out-Of-Pocket Limit; Stop Loss Provision for Copayments

Total copayment expenses for outpatient services and the outpatient supplies such as hospital emergency room visits, ambulance/transportation services, inpatient hospital stays, and inpatient mental health care stays, are limited to an aggregate annual maximum of \$3,000 per calendar year per member. The Optimal plan has an aggregate annual maximum of \$1,500 per calendar year per member.

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 at 1-888-901-4600 and ask for the "Evidence of Coverage."

## Clear Care HMO service area zip codes

98001	98035	98074	98125	98184	98235	98272	98321	98367	98407	98481	98541	99004	99209
98002	98036	98075	98126	98185	98236	98273	98322	98370	98408	98490	98542	99005	99210
98003	98037	98077	98127	98188	98237	98274	98323	98371	98409	98492	98544	99006	99211
98004	98038	98082	98129	98190	98238	98275	98327	98372	98411	98493	98546	99009	99212
98005	98039	98083	98131	98191	98239	98276	98328	98373	98412	98496	98548	99011	99213
98006	98040	98087	98132	98194	98240	98277	98329	98374	98413	98497	98555	99012	99214
98007	98041	98089	98133	98195	98241	98278	98330	98375	98415	98498	98556	99014	99215
98008	98042	98092	98134	98198	98243	98279	98332	98377	98416	98499	98557	99016	99216
98009	98043	98093	98136	98199	98244	98280	98333	98378	98417	98501	98558	99018	99217
98010	98045	98101	98138	98201	98245	98281	98335	98380	98418	98502	98559	99019	99218
98011	98046	98102	98139	98203	98247	98282	98336	98383	98419	98503	98564	99020	99219
98012	98047	98103	98141	98204	98248	98283	98337	98384	98421	98504	98565	99021	99220
98013	98050	98104	98144	98205	98249	98284	98338	98385	98422	98505	98568	99022	99223
98014	98051	98105	98145	98206	98250	98286	98340	98386	98424	98506	98570	99023	99224
98015	98052	98106	98146	98207	98251	98287	98342	98387	98430	98507	98572	99025	99228
98019	98053	98107	98148	98208	98252	98288	98344	98388	98431	98508	98576	99026	99251
98020	98054	98108	98154	98213	98253	98290	98345	98390	98433	98509	98579	99027	99252
98021	98055	98109	98155	98220	98255	98291	98346	98391	98438	98511	98580	99029	99256
98022	98056	98110	98158	98221	98256	98292	98348	98392	98439	98512	98582	99030	99258
98023	98057	98111	98160	98222	98257	98293	98349	98393	98442	98513	98584	99031	99260
98024	98058	98112	98161	98223	98258	98294	98351	98394	98443	98516	98585	99036	99299
98025	98059	98113	98164	98224	98259	98295	98352	98395	98444	98522	98588	99037	
98026	98061	98114	98165	98225	98260	98296	98353	98396	98445	98524	98589	99039	
98027	98062	98115	98166	98226	98261	98297	98354	98397	98446	98528	98591	99201	
98028	98063	98116	98168	98227	98262	98303	98355	98398	98447	98530	98592	99202	
98029	98064	98117	98171	98228	98263	98304	98356	98401	98448	98531	98593	99203	
98030	98065	98118	98174	98229	98264	98310	98359	98402	98464	98532	98596	99204	
98031	98070	98119	98175	98230	98266	98311	98360	98403	98465	98533	98597	99205	
98032	98071	98121	98177	98231	98267	98312	98361	98404	98466	98538	98599	99206	
98033	98072	98122	98178	98232	98270	98314	98364	98405	98467	98539	99001	99207	
98034	98073	98124	98181	98233	98271	98315	98366	98406	98471	98540	99003	99208	



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

H5050\_10SBMTX20909

210GHMC 10-09