CLEAR CARE® | PPO

SUMMARY OF BENEFITS

Clear Care Prestige (PPO)

Clear Care Elite (PPO)

BENEFITS EFFECTIVE:

JAN 1, 2010 – DEC 31, 2010

COUNTIES SERVED:

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

H2810

GroupHealth®

Thank you for your interest in the Clear Care Prestige (PPO) and Clear Care Elite (PPO) plans.

Our plans are offered by Group Health Options, Inc., a Medicare Advantage Preferred Provider Organization (PPO). 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 Customer Service 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 our Clear Care Prestige and Clear Care Elite 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's 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 the Clear Care Prestige and Clear Care Elite 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 PPO plans available?

There are two plans 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: Clallam and Jefferson (Clallam and Jefferson include only these ZIP codes: 98382, 98362, 98368, 98363, 98339, 98325, and 98358.); Benton, Franklin and Yakima. You must live in one of these areas to join one of these plans. Please see the back of this brochure for a list of all the Clear Care PPO service area zip codes.

Who is eligible to join the Clear Care PPO plans?

You can join a Clear Care PPO 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 PPO plan unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?

Group Health Options has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of the 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. Our Customer Service number is listed again at the end of this introduction.

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

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

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

Clear Care Prestige and Clear Care Elite plans do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where can I get my prescription if I join the Clear Care Prestige or the Clear Care Elite plan?

Group Health Options 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 directory or visit us at www.ghc.org and click on Pharmacy Services. Please call Customer Service for more information.

What is a prescription drug formulary?

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

What are my protections on the Clear Care Prestige and Clear Care Elite 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.

As a member of the Clear Care Prestige or the Clear Care Elite plan, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualis Health at 1-800-949-7536.

As a member of the Clear Care Prestige or the Clear Care Elite 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. 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 the Customer Service department for more details.

What types of drugs may be covered under Medicare Part B?

The following outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Customer Service 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** 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 Customer Service 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 Prestige or the Clear Care Elite plan. Visit us at **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.–5 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 on the Web.

Group Health Options, Inc. 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. If you have special needs, this document may be available in other formats.

Important information

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
1 Premium and Other Important Information	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. 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.	GENERAL $37 is the monthly plan premium in addition to your Medicare Part B premium IN- AND OUT-OF-NETWORK $100 yearly deductible. Contact the plan for services that apply. $3,200 out-of-pocket limit There is no limit on cost sharing for the following services: IN-NETWORK Supplemental Services: • Dental Services • Hearing Services • Vision Services OUT-OF-NETWORK Supplemental Services: • Dental Services • Hearing Services • Vision Services	GENERAL $78 is the monthly plan premium in addition to your Medicare Part B premium IN- AND OUT-OF-NETWORK $100 yearly deductible. Contact the plan for services that apply. $2,500 out-of-pocket limit There is no limit on cost sharing for the following services: IN-NETWORK Supplemental Services: • Dental Services • Hearing Services • Vision Services OUT-OF-NETWORK: Supplemental Services: • Dental Services • Hearing Services • Vision Services
2 Doctor and Hospital Choice (For more information, see Emergency–#15 and Urgently Needed Care–#16)	You may go to any doctor, specialist, or hospital that accepts Medicare.	IN-NETWORK No referral required for network doctors, specialists and hospitals	IN-NETWORK No referral required for network doctors, specialists and hospitals

Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were: • Days 1–60: $1,068 deductible • Days 61–90: $267 per day • Days 91–150: $534 per lifetime reserve day These amounts will change for 2010. Please 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 For Medicare-covered hospital stays: • Days 1–5: $200 copay per day • Days 6–90: $0 copay per day The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to. $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period OUT-OF-NETWORK For hospital stays: • Days 1–5: $400 copay per day • Days 6–90: $0 copay per day	IN-NETWORK For Medicare-covered hospital stays: • Days 1–5: $100 copay per day • Days 6–90: $0 copay per day The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to. $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. OUT-OF-NETWORK For Medicare-covered hospital stays: • Days 1–5: $300 copay per day • Days 6–90: $0 copay per day
4 Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above) 190-day lifetime limit in a Psychiatric Hospital	IN-NETWORK For Medicare-covered hospital stays: • Days 1–5: $200 copay per day • Days 6–90: $0 copay per day The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. OUT-OF-NETWORK For hospital stays: • Days 1–5: $400 copay per day • Days 6–90: $0 copay per day	IN-NETWORK For Medicare-covered hospital stays: • Days 1–5: $100 copay per day • Days 6–90: $0 copay per day The amount you pay for each Medicare-covered stay may vary depending on which hospital you go to. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. OUT-OF-NETWORK For hospital stays: • Days 1–5: $300 copay per day • Days 6–90: $0 copay per day

Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
5 Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: • Days 1–20: $0 per day • Days 21–100: $133.50 per day These amounts will change for 2010. • 100 days for each benefit period 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.	GENERAL Authorization rules may apply IN-NETWORK **For SNF stays:** • Days 1–100: $50 copay per day • Plan covers up to 100 days for each benefit period • No prior hospital stay is required OUT-OF-NETWORK $75 per SNF day	GENERAL Authorization rules may apply IN-NETWORK **For SNF stays:** • Days 1–100: $25 copay per day • Plan covers up to 100 days for each benefit period • No prior hospital stay is required OUT-OF-NETWORK $50 per SNF day
6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay	IN-NETWORK $0 copay for Medicare-covered home health visits OUT-OF-NETWORK 20% for home health visits	IN-NETWORK $0 copay for Medicare-covered home health visits OUT-OF-NETWORK 20% for home health visits
7 Hospice	You pay part of the cost for outpatient drugs and inpatient respite care You must get care from a Medicare-certified hospice	GENERAL You must get care from a Medicare-certified hospice	GENERAL You must get care from a Medicare-certified hospice
8 Doctor Office Visits	20% coinsurance	GENERAL See "Physical Exams" for more information IN-NETWORK $20 copay for each primary care doctor visit for Medicare-covered benefits $20 copay for each in-area network urgent care Medicare-covered visit $40 copay for each specialist visit for Medicare-covered benefits OUT-OF-NETWORK $35 copay for each primary care doctor visit $55 copay for each specialist visit	GENERAL See "Physical Exams" for more information 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 $30 copay for each specialist visit for Medicare-covered benefits OUT-OF-NETWORK $25 copay for each primary care doctor visit $45 copay for each specialist visit

Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
9 Chiropractic Services	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 provider.	IN-NETWORK $20 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a subluxation (displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider. OUT-OF-NETWORK $35 copay for chiropractic benefits	IN-NETWORK $10 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a subluxation (displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider. OUT-OF-NETWORK $25 copay for chiropractic benefits
10 Podiatry Services	Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	GENERAL Authorization rules may apply IN-NETWORK $40 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care OUT-OF-NETWORK $55 copay for podiatry benefits	GENERAL Authorization rules may apply IN-NETWORK $30 copay for each Medicare-covered visit Medicare-covered podiatry benefits are for medically necessary foot care OUT-OF-NETWORK $45 copay for podiatry benefits
11 Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services	GENERAL Authorization rules may apply IN-NETWORK $20 copay for each Medicare-covered individual or group therapy visit OUT-OF-NETWORK $35 copay for Mental Health benefits $35 copay for Mental Health benefits with a psychiatrist	GENERAL Authorization rules may apply IN-NETWORK $10 copay for each Medicare-covered individual or group therapy visit OUT-OF-NETWORK $25 copay for Mental Health benefits $25 copay for Mental Health benefits with a psychiatrist
12 Outpatient Substance Abuse Care	20% coinsurance	IN-NETWORK $20 copay for Medicare-covered individual visits or group visits OUT-OF-NETWORK $35 copay for outpatient substance abuse benefits	IN-NETWORK $10 copay for Medicare-covered individual visits or group visits OUT-OF-NETWORK $25 copay for outpatient substance abuse benefits

Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
13 Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	IN-NETWORK $200 copay for each Medicare-covered ambulatory surgical center visit $200 copay for each Medicare-covered outpatient hospital facility visit OUT-OF-NETWORK $400 copay for ambulatory surgical center benefits $400 copay for outpatient hospital facility benefits	GENERAL Authorization rules may apply IN-NETWORK $100 copay for each Medicare-covered ambulatory surgical center visit $100 copay for each Medicare-covered outpatient hospital facility visit OUT-OF-NETWORK $300 copay for ambulatory surgical center benefits $300 copay for outpatient hospital facility benefits
14 Ambulance Services (medically necessary ambulance services)	20% coinsurance	IN-NETWORK $150 copay for Medicare-covered ambulance benefits OUT-OF-NETWORK $150 copay for ambulance benefits	IN-NETWORK $100 copay for Medicare-covered ambulance benefits OUT-OF-NETWORK $100 copay for ambulance benefits
15 Emergency Care (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	GENERAL $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.	GENERAL $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.
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 $20 copay for Medicare-covered urgently needed care visits	GENERAL $10 copay for Medicare-covered urgently needed care visits

Outpatient medical services and supplies

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	IN-NETWORK $20 copay for Medicare-covered Occupational Therapy visits $20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits OUT-OF-NETWORK $35 copay for Occupational Therapy benefits $35 copay for Physical and/or Speech/Language Therapy visits	GENERAL Authorization rules may apply IN-NETWORK $10 copay for Medicare-covered Occupational Therapy visits $10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits OUT-OF-NETWORK $25 copay for Occupational Therapy benefits $25 copay for Physical and/or Speech/Language Therapy visits
18 Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	GENERAL Authorization rules may apply IN-NETWORK 20% of the cost for Medicare-covered items OUT-OF-NETWORK 40% of the cost for durable medical equipment	GENERAL Authorization rules may apply IN-NETWORK 20% of the cost for Medicare-covered items OUT-OF-NETWORK 40% of the cost for durable medical equipment
19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	GENERAL Authorization rules may apply IN-NETWORK 20% of the cost for Medicare-covered items OUT-OF-NETWORK 40% of the cost for prosthetic devices	GENERAL Authorization rules may apply IN-NETWORK 20% of the cost for Medicare-covered items OUT-OF-NETWORK 40% of the cost for prosthetic devices

Outpatient medical services and supplies

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
20 Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (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.	GENERAL Authorization rules may apply IN-NETWORK $0 copay for diabetes self-monitoring training $0 copay for nutrition therapy for diabetes 20% of the cost for diabetes supplies OUT-OF-NETWORK $0 copay for diabetes self-monitoring training $0 copay for nutrition therapy for diabetes 40% of the cost for diabetes supplies	IN-NETWORK $0 copay for diabetes self-monitoring training $0copay for nutrition therapy for diabetes 20% of the cost for diabetes supplies OUT-OF-NETWORK $0 copay for diabetes self-monitoring training $0 copay for nutrition therapy for diabetes 40% of the cost for diabetes supplies
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 routine screening tests, like checking your cholesterol.	GENERAL Authorization rules may apply IN-NETWORK • $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests • $0 copay for Medicare-covered X-rays • $75 copay for Medicare-covered diagnostic radiology services • $0 copay for Medicare-covered therapeutic radiology services. OUT-OF-NETWORK • $0 copay for diagnostic procedures, tests, and lab services • $0 copay for therapeutic radiology services • $0 copay for outpatient X-rays • $150 copay for diagnostic radiology services	GENERAL Authorization rules may apply IN-NETWORK • $0 copay for Medicare-covered: – lab services – diagnostic procedures and tests • $0 copay for Medicare-covered X-rays • $50 copay for Medicare-covered diagnostic radiology services • $0 copay for Medicare-covered therapeutic radiology services. OUT-OF-NETWORK • $0 copay for diagnostic procedures, tests, and lab services • $0 copay for therapeutic radiology services • $0 copay for outpatient X-rays • $100 copay for diagnostic radiology services

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
22 Bone Mass Measurement (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	IN-NETWORK $0 copay for Medicare-covered bone mass measurement OUT-OF-NETWORK $0 copay for Medicare-covered bone mass measurement	IN-NETWORK $0 copay for Medicare-covered bone mass measurement OUT-OF-NETWORK $0 copay for Medicare-covered bone mass measurement
23 Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older	IN-NETWORK $0 copay for Medicare-covered colorectal screenings OUT-OF-NETWORK $0 copay for colorectal screenings	IN-NETWORK $0 copay for Medicare-covered colorectal screenings OUT-OF-NETWORK $0 copay for colorectal screenings
24 Immunizations (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.	IN-NETWORK $0 copay for flu and pneumonia vaccines $0 copay for hepatitis B vaccine No referral needed for flu and pneumonia vaccines No referral needed for other immunizations OUT-OF-NETWORK $0 copay for immunizations	IN-NETWORK $0 copay for flu and pneumonia vaccines $0 copay for hepatitis B vaccine No referral needed for flu and pneumonia vaccines No referral needed for other immunizations OUT-OF-NETWORK $0 copay for immunizations
25 Mammograms (Annual Screening) (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.	IN-NETWORK $0 copay for Medicare-covered screening mammograms OUT-OF-NETWORK $0 copay for screening mammograms	IN-NETWORK $0 copay for Medicare-covered screening mammograms OUT-OF-NETWORK $0 copay for screening mammograms
26 Pap Smears and Pelvic Exams (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	IN-NETWORK $0 copay for Medicare-covered Pap smears and pelvic exams OUT-OF-NETWORK $0 copay for Pap smears and pelvic exams	IN-NETWORK $0 copay for Medicare-covered Pap smears and pelvic exams OUT-OF-NETWORK $0 copay for Pap smears and pelvic exams

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
27 Prostate Cancer Screening Exams (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	IN-NETWORK $0 copay for Medicare-covered prostate cancer screening OUT-OF-NETWORK $0 copay for prostate cancer screening	IN-NETWORK $0 copay for Medicare-covered prostate cancer screening OUT-OF-NETWORK $0 copay for prostate cancer screening
28 End Stage Renal Disease	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.	IN-NETWORK $0 copay for renal dialysis $0 copay for nutrition therapy for End Stage Renal Disease OUT-OF-NETWORK $0 copay for renal dialysis $0 copay for nutrition therapy for End Stage Renal Disease	IN-NETWORK $0 copay for renal dialysis $0 copay for nutrition therapy for End Stage Renal Disease OUT-OF-NETWORK $0 copay for renal dialysis $0 copay for nutrition therapy for End Stage Renal Disease
29 Prescription Drugs	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.	**Drugs covered under Medicare Part B** GENERAL $0 copay for Part B covered drugs $0 copay for Part B drugs out-of-network **Drugs covered under Medicare Part C** 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.	**Drugs covered under Medicare Part B** GENERAL $0 copay for Part B covered drugs $0 copay for Part B drugs out-of-network **Drugs covered under Medicare Part C** 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.

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
29 Prescription Drugs *Continued*		**Drugs covered under Medicare Part D** GENERAL This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ghc.org 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. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details. Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Group Health Option's Clear Care Prestige (PPO) 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. 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.	**Drugs covered under Medicare Part D** GENERAL This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ghc.org 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. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details. Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Group Health Option's Clear Care Elite (PPO) 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. 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.

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
29 Prescription Drugs *Continued*		IN-NETWORK $310 yearly deductible	IN-NETWORK $0 yearly deductible
IN-NETWORK		INITIAL COVERAGE After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,830: RETAIL PHARMACY Preferred Generic • $6 copay for a one-month (30-day) supply of drugs in this tier • $18 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Preferred Brand • $17 copay for a one-month (30-day) supply of drugs in this tier • $51 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Nonpreferred • 50% coinsurance for a one-month (30-day) supply of drugs in this tier • 50% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information.	INITIAL COVERAGE You pay the following until total yearly drug costs reach $2,830: RETAIL PHARMACY Preferred Generic • $9 copay for a one-month (30-day) supply of drugs in this tier • $27 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Preferred Brand • $15 copay for a one-month (30-day) supply of drugs in this tier • $45 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Nonpreferred • 50% coinsurance for a one-month (30-day) supply of drugs in this tier • 50% coinsurance for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information.

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
29 Prescription Drugs *Continued* IN-NETWORK		LONG TERM CARE PHARMACY Preferred Generic • $6 copay for a one-month (31-day) supply of drugs in this tier Preferred Brand • $17 copay for a one-month (31-day) supply of drugs in this tier Nonpreferred • 50% coinsurance for a one-month (31-day) supply of drugs in this tier	LONG TERM CARE PHARMACY Preferred Generic • $9 copay for a one-month (31-day) supply of drugs in this tier Preferred Brand • $15 copay for a one-month (31-day) supply of drugs in this tier Nonpreferred • 50% coinsurance for a one-month (31-day) supply of drugs in this tier
		MAIL ORDER Preferred Generic • $6 copay for a one-month (30-day) supply of drugs in this tier • $18 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Preferred Brand • $17 copay for a one-month (30-day) supply of drugs in this tier • $51 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Nonpreferred • 50% coinsurance for a one-month (30-day) supply of drugs in this tier • 50% coinsurance for a one-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information.	MAIL ORDER Preferred Generic • $9 copay for a one-month (30-day) supply of drugs in this tier • $27 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Preferred Brand • $15 copay for a one-month (30-day) supply of drugs in this tier • $45 copay for a three-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information. Nonpreferred • 50% coinsurance for a one-month (30-day) supply of drugs in this tier • 50% coinsurance for a one-month (90-day) supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact Customer Service for more information.

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
29 Prescription Drugs *Continued* IN-NETWORK		COVERAGE GAP After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	COVERAGE GAP After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.
		CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance	CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance
OUT-OF-NETWORK		OUT-OF-NETWORK Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Group Health Options.	OUT-OF-NETWORK Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Group Health Options.
		INITIAL COVERAGE After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: Preferred Generic • $6 copay for a one-month (30-day) supply of drugs in this tier Preferred Brand • $17 copay for a one-month (30-day) supply of drugs in this tier Nonpreferred Generic/Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier	INITIAL COVERAGE You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: Preferred Generic • $9 copay for a one-month (30-day) supply of drugs in this tier Preferred Brand • $15 copay for a one-month (30-day) supply of drugs in this tier Nonpreferred Generic/Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
29 Prescription Drugs *Continued* OUT-OF-NETWORK		OUT-OF-NETWORK COVERAGE GAP 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 this plan 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.	OUT-OF-NETWORK COVERAGE GAP 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 this plan 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.
		OUT-OF-NETWORK CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance	OUT-OF-NETWORK CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance
30 Dental Services	Preventive dental services (such as cleaning) not covered	IN-NETWORK 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"). 0% of the cost for Medicare-covered dental benefits OUT-OF-NETWORK 0% of the cost for comprehensive dental benefits	IN-NETWORK 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"). 0% of the cost for Medicare-covered dental benefits OUT-OF-NETWORK $0 copay for the cost for comprehensive dental benefits

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
31 Hearing Services	Routine hearing exams and hearing aids not covered 20% coinsurance for diagnostic hearing exams	IN-NETWORK Hearing aids not covered. • $20 copay for Medicare covered diagnostic hearing exams • $20 copay for up to 1 routine hearing test • $0 copay for up to 1 hearing aid fitting evaluation OUT-OF-NETWORK • $35 copay for hearing exams	IN-NETWORK Hearing aids not covered. • $10 copay for Medicare covered diagnostic hearing exams • $10 copay for up to 1 routine hearing test • $0 copay for up to 1 hearing aid fitting evaluation OUT-OF-NETWORK • $25 copay for hearing exams
32 Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye Routine eye exams and glasses not covered Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery Annual glaucoma screenings covered for people at risk	IN-NETWORK • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery • $20 copay for exams to diagnose and treat diseases and conditions of the eye • $0 copay for up to 1 routine eye exam every year OUT-OF-NETWORK • $35 copay for eye exams • $0 copay for eye wear	IN-NETWORK • $0 copay for one pair of eyeglasses or contact lenses after cataract surgery • $10 copay for exams to diagnose and treat diseases and conditions of the eye • $0 copay for up to 1 routine eye exam every year OUT-OF-NETWORK • $25 copay for eye exams • $0 copay for eye wear
33 Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. 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.	IN-NETWORK • $0 copay for routine exams • Limited to 1 exam every year • $20 copay for Medicare-covered benefits OUT-OF-NETWORK • $35 copay for routine exams	IN-NETWORK • $0 copay for routine exams • Limited to 1 exam every year • $10 copay for Medicare-covered benefits OUT-OF-NETWORK • $25 copay for routine exams

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
34 Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance and Part B deductible applies.	IN-NETWORK This plan covers the following health/wellness education benefits: • Additional Smoking Cessation • Consulting Nurse Service • $0 copay for each Medicare-covered smoking cessation counselling session OUT-OF-NETWORK • $0 copay for Health and Wellness Services	IN-NETWORK This plan covers the following health/wellness education benefits: • Additional Smoking Cessation • Consulting Nurse Service • $0 copay for each Medicare-covered smoking cessation counselling session OUT-OF-NETWORK • $0 copay for Health and Wellness Services
35 Transportation (Routine)	Not covered	IN-NETWORK This plan does not cover routine transportation	IN-NETWORK This plan does not cover routine transportation
36 Acupuncture	Not covered	IN-NETWORK This plan does not cover Acupuncture	IN-NETWORK This plan does not cover Acupuncture

Optional supplemental package 1

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE PRESTIGE PPO	CLEAR CARE ELITE PPO
Premium and other important information **Dental Services**		GENERAL Package 1: Dental $48 monthly premium, in addition to your $37 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 IN-NETWORK $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 OUT-OF-NETWORK • 20% of the cost for preventive dental services • 30% to 60% of the cost for comprehensive dental services	GENERAL Package 1: Dental $48 monthly premium, in addition to your $78 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 IN-NETWORK $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 OUT-OF-NETWORK • 20% of the cost for preventive dental services • 30% to 60% of the cost for comprehensive dental services

When you join a Clear Care PPO plan you will also receive additional benefits as a Group Health Options member. You'll have access to the following services, and more:

YOU CAN

- Select from hundreds of contracted personal physicians in the PPO service areas
- Select from a large number of contracted specialists in the PPO service areas
- Change doctors anytime

YOU'LL GET

- Use of the 24-hour Consulting Nurse helpline
- An online library of more than 5,000 health topics
- 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

OTHER PERKS

- The Global Fit® discount fitness program
- Prescription refills by mail
- Weight Watchers®

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 in-network paid at 100% and out-of-network paid at 80% 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. Skilled nursing facility stays must meet Medicare criteria. All in-network stays must meet Medicare criteria and the stay must be authorized 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 $3,200 for the Clear Care Prestige plan and $2,500 for the Clear Care Elite plan 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 Options at 1-888-901-4600 and ask for the "Evidence of Coverage."

Clear Care PPO Service area zip codes

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

www.ghc.org
1-800-446-8882

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