

Clear CareSM plan benefits

Group Health's Medicare Advantage plans

- Clear Care Basic
- Clear Care Essential
- Clear Care Optimal

Benefits effective January 1, 2009 – December 31, 2009



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 Basic, Clear Care Essential, and Clear Care Optimal 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'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 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: Mason and Grays Harbor (Mason County and Grays Harbor County include only these ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592, 98541, 98557, 98559 and 98568), Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom counties in Washington. You must live in one of these areas to join one of these plans.

Who is eligible to join Group Health's Clear Care plans?

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. 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 two plans with Part D prescription drug coverage: Clear Care Essential and Clear Care Optimal.

Where can I get my prescription if I am enrolled in or choose the 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/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html. Our Customer Service number is listed at the end of this introduction.

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/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html.

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

How can I get extra help with prescription drug plan costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Clear Care Essential or Clear Care Optimal, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 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.

What are my protections on the 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 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Clear Care Essential and Clear Care Optimal, 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.

What is the Medication Therapy Management Program?

A Medication Therapy Management (MTM) Program is a free service we may offer through the 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?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is 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.

Please call Group Health Cooperative for more information about these plans.

Visit us at www.ghc.org/medicare or, call us:

Customer Service hours:

Monday, Tuesday, Wednesday, Thursday, Friday,
8 a.m.–8 p.m. Pacific.

Current members should 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 should call 1-800-446-8882 for questions related to the Medicare Advantage program and the Medicare Part D Prescription Drug program (TTY/TDD 1-800-833-6388).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048.
You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the Web.

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 Basic	Clear Care Essential	Clear Care Optimal
<p>1 Premium and Other Important Information</p>	<p>In 2009 the monthly Part B premium is \$96.40 and the yearly Part B deductible amount is \$135.</p>	<p>General \$75 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p>In-Network \$2500 in-network out-of-pocket limit. Not all plan services are covered under the out-of-pocket limit. Cost shares associated with the following benefits do not apply to out-of-pocket limit.</p>	<p>General \$168 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p>In-Network \$2500 in-network out-of-pocket limit. Not all plan services are covered under the out-of-pocket limit. Cost shares associated with the following benefits do not apply to out-of-pocket limit.</p>	<p>General \$225 is the monthly plan premium in addition to your Medicare Part B premium.</p> <p>In-Network \$1000 in-network out-of-pocket limit. Not all plan services are covered under the out-of-pocket limit. Cost shares associated with the following benefits do not apply to out-of-pocket limit.</p>
<p>2 Doctor and Hospital Choice (For more information, see Emergency—#15 and Urgently Needed Care—#16)</p>	<p>You may go to any doctor, specialist, or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).</p> <p>Out-of-Network Plan covers you when you are in the U.S.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).</p> <p>Out-of-Network Plan covers you when you are in the U.S.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).</p> <p>Out-of-Network Plan covers you when you are in the U.S.</p>

SUMMARY OF BENEFITS: INPATIENT CARE

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period are:</p> <p>Days 1–60: \$1,068 deductible</p> <p>Days 61–90: \$267 per day</p> <p>Days 91–150: \$534 per lifetime reserve day</p> <p>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.</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1–5: \$200 copay per day</p> <p>Days 6–90: \$0 copay per day</p> <p>\$0 copay for additional hospital days.</p> <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>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1–5: \$200 copay per day</p> <p>Days 6–90: \$0 copay per day</p> <p>\$0 copay for additional hospital days.</p> <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>In-Network</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1–3: \$100 copay per day</p> <p>Days 4–90: \$0 copay per day</p> <p>\$0 copay for additional hospital days.</p> <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>

INPATIENT CARE (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>4 Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190-day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network For hospital stays: Days 1–5: \$200 copay per day Days 6–90: \$0 copay per day 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.</p>	<p>In-Network For hospital stays: Days 1–5: \$200 copay per day Days 6–90: \$0 copay per day 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.</p>	<p>In-Network For hospital stays: Days 1–3: \$100 copay per day Days 4–90: \$0 copay per day 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.</p>
<p>5 Skilled Nursing Facility (SNF) (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 are: Days 1–20: \$0 per day Days 21–100: \$133.50 per day 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.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for SNF services. 100 days covered for each benefit period. No prior hospital stay is required.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for SNF services. 100 days covered for each benefit period. No prior hospital stay is required.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for SNF services. 150 days covered for each benefit period. No prior hospital stay is required.</p>

INPATIENT CARE (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p>
<p>7 Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

OUTPATIENT CARE

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>8 Doctor Office Visits</p>	<p>20% coinsurance.</p>	<p>General See "Routine Physical Exams" for more information. Authorization rules may apply.</p> <p>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. \$20 copay for each specialist visit for Medicare-covered benefits.</p>	<p>General See "Routine Physical Exams" for more information. Authorization rules may apply.</p> <p>In-Network \$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>General See "Routine Physical Exams" for more information. Authorization rules may apply.</p> <p>In-Network \$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>9 Chiropractic Services</p>	<p>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.</p>	<p>In-Network \$20 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>	<p>In-Network \$15 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>	<p>In-Network \$15 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>

OUTPATIENT CARE (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
10 Podiatry Services	<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>General Authorization rules may apply.</p> <p>In-Network \$20 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p>
11 Outpatient Mental Health Care	<p>50% coinsurance for most outpatient mental health services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>
12 Outpatient Substance Abuse Care	<p>20% coinsurance.</p>	<p>In-Network \$0 copay for Medicare-covered visits.</p>	<p>In-Network \$0 copay for Medicare-covered visits.</p>	<p>In-Network \$0 copay for Medicare-covered visits.</p>

OUTPATIENT CARE (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>13 Outpatient Services/Surgery</p>	<p>20% coinsurance for the doctor. 20% of outpatient facility.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$200 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit.</p>
<p>14 Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$75 copay for Medicare-covered ambulance benefits.</p>
<p>15 Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>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.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In- and Out-of-Network If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visits.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In- and Out-of-Network If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visits.</p>	<p>In-Network \$50 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In- and Out-of-Network If you are admitted to the hospital within 1-day for the same condition, you pay \$0 for the emergency room visits.</p>

OUTPATIENT CARE (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>16 Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$20 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>
<p>17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for Medicare-covered Occupational Therapy visits. \$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for Medicare-covered Occupational Therapy visits. \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$15 copay for Medicare-covered Occupational Therapy visits. \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
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.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
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.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
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.	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.	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.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>21 Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and X-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services 	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services 	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> • lab services • diagnostic procedures and tests • X-rays • diagnostic radiology services (not including X-rays) • therapeutic radiology services
<p>22 Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>20% coinsurance.</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p>

PREVENTIVE SERVICES

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
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.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered colorectal screenings.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered colorectal screenings.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered 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.	General Authorization rules may apply. In-Network \$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.	General Authorization rules may apply. In-Network \$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.	General Authorization rules may apply. In-Network \$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.
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.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>26 Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$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.</p>	<p>In-Network \$0 copay for Medicare-covered Pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered Pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered Pap smears and pelvic exams.</p>
<p>27 Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>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.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>
<p>28 End Stage Renal Disease</p>	<p>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.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for in and out-of-area dialysis. \$0 copay for nutrition therapy for renal disease.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for in and out-of-area dialysis. \$0 copay for nutrition therapy for renal disease.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for renal dialysis. \$0 copay for nutrition therapy for renal disease.</p>

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>29 Prescription Drugs</p>	<p>Most drugs 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>Drugs covered under Medicare Part B \$0 copay for Part B covered drugs.</p> <p>General Most drugs not covered. Drugs covered under Medicare Part D.</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part D \$0 copay for Part B covered drugs.</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ghc.org/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html on the Web. Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service). Your in-network prescription coverage is limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p>	<p>Drugs covered under Medicare Part D \$0 copay for Part B covered drugs.</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ghc.org/health_plans/index.jhtml?repositid=/common/healthPlans/Medicare/aboutPartDFormulary.html on the Web. Different out-of-pocket costs may apply for people who have limited incomes, live in long term care facilities, or have access to Indian/Tribal/Urban (Indian Health Service). Your in-network prescription coverage is limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network pharmacy although you may have to pay additional charges. Contact the plan for details.</p>

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>29 Prescription Drugs (continued)</p>			<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Clear Care Essential for certain drugs.</p> <p>If the actual cost of a drug is less than the normal cost sharing amount for that drug, you will pay the actual cost, not the higher cost sharing amount.</p>	<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Clear Care Optimal for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>
<p>In-Network</p>			<p>In-Network \$295 yearly deductible.</p>	<p>In-Network \$0 deductible.</p>
<p>Initial Coverage</p>			<p>Initial Coverage</p> <p>After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2700:</p> <p><i>Retail Pharmacy Preferred Generic</i></p> <ul style="list-style-type: none"> • 15% coinsurance for a one-month (30-day) supply of drugs in this tier • 15% coinsurance for a three-month (90-day) supply of drugs in this tier 	<p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2700:</p> <p><i>Retail Pharmacy Preferred Generic</i></p> <ul style="list-style-type: none"> • \$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

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>29 Prescription Drugs (continued)</p>			<p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • 30% coinsurance for a one-month (30-day) supply of drugs • 30% coinsurance for a three-month (90-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs • 50% coinsurance for a three-month (90-day) supply of drugs 	<p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • \$15 copay for a one-month (30-day) supply of drugs • \$45 copay for a three-month (90-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs • 50% coinsurance for a three-month (90-day) supply of drugs
<p>Long Term Care Pharmacy</p>			<p>Long Term Care Pharmacy <i>Preferred Generic</i></p> <ul style="list-style-type: none"> • 15% coinsurance for a one-month (31-day) supply of drugs <p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • 30% coinsurance for a one-month (31-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (31-day) supply of drugs 	<p>Long Term Care Pharmacy <i>Preferred Generic</i></p> <ul style="list-style-type: none"> • \$9 copay for a one-month (31-day) supply of drugs <p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • \$15 copay for a one-month (31-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (31-day) supply of drugs
<p>Mail Order</p>			<p>Mail Order <i>Preferred Generic</i></p> <ul style="list-style-type: none"> • 15% coinsurance for a one-month (30-day) supply of drugs • 15% coinsurance for a three-month (90-day) supply of drugs 	<p>Mail Order <i>Preferred Generic</i></p> <ul style="list-style-type: none"> • \$9 copay for a one-month (30-day) supply of drugs • \$27 copay for a three-month (90-day) supply of drugs

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
29 Prescription Drugs (continued)			<p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • 30% coinsurance for a one-month (30-day) supply of drugs • 30% coinsurance for a three-month (90-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs • 50% coinsurance for a three-month (90-day) supply of drugs 	<p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • \$15 copay for a one-month (30-day) supply of drugs • \$45 copay for a three-month (90-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs • 50% coinsurance for a three-month (90-day) supply of drugs
Coverage Gap			<p>Coverage Gap After your total yearly drug costs reach \$2700, you pay 100% until your yearly out-of-pocket drug costs reach \$4350.</p>	<p>Coverage Gap After your total yearly drug costs reach \$2700, you pay 100% until your yearly out-of-pocket drug costs reach \$4350.</p>
Catastrophic Coverage			<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4350, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.40 copay for generic (including brand drugs treated as generic) and \$6.00 copay for all other drugs, or • 5% coinsurance. 	<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4350, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.40 copay for generic (including brand drugs treated as generic) and \$6.00 copay for all other drugs, or • 5% coinsurance.

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
29 Prescription Drugs (continued)				
Out-of-Network			<p>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.</p> <p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement.</p>	<p>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.</p> <p>In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement.</p>
Out-of-Network Initial Coverage			<p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2700:</p>	<p>Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2700:</p>
Out-of-Network Pharmacy			<p>Out-of-Network Pharmacy</p> <p><i>Preferred Generic</i></p> <ul style="list-style-type: none"> • 15% coinsurance for a one-month (30-day) supply of drugs <p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • 30% coinsurance for a one-month (30-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs 	<p>Out-of-Network Pharmacy</p> <p><i>Preferred Generic</i></p> <ul style="list-style-type: none"> • \$9 copay for a one-month (30-day) supply of drugs <p><i>Preferred Brand</i></p> <ul style="list-style-type: none"> • \$15 copay for a one-month (30-day) supply of drugs <p><i>Non-Preferred Generic/Brand</i></p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>29 Prescription Drugs (continued)</p> <hr/> <p>Coverage Gap</p>			<p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4350. 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.</p>	<p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2700, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4350. 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.</p>
<p>Catastrophic Coverage</p>			<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4350, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.40 copay for generic (including brand drugs treated as generic) and \$6.00 copay for all other drugs, or • 5% coinsurance 	<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4350, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.40 copay for generic (including brand drugs treated as generic) and \$6.00 copay for all other drugs, or • 5% coinsurance

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>30 Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). 0% of the cost for Medicare-covered dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). 0% of the cost for Medicare-covered dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). 0% of the cost for Medicare-covered dental benefits.</p>
<p>31 Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.</p>	<p>General Authorization rules may apply</p> <p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> • \$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 	<p>General Authorization rules may apply</p> <p>In-Network Hearing aids not covered.</p> <ul style="list-style-type: none"> • \$15 copay for Medicare covered diagnostic hearing exams • \$15 copay for up to 1 routine hearing test • \$0 copay for up to 1 hearing aid fitting evaluation 	<p>General Authorization rules may apply</p> <p>In-Network \$0 copay for up to 1 hearing aid.</p> <ul style="list-style-type: none"> • \$15 copay for Medicare covered diagnostic hearing exams • \$15 copay for up to 1 routine hearing test • \$0 copay for up to 1 hearing aid fitting evaluation <p>\$500 limit for routine hearing aids.</p>

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>32 Vision Services</p>	<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>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • one pair of eyeglasses or contact lenses after cataract surgery • \$20 copay for exams to diagnose and treat diseases and conditions of the eye • \$20 copay for up to 1 routine eye exam 	<p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • one pair of eyeglasses or contact lenses after cataract surgery • \$15 copay for exams to diagnose and treat diseases and conditions of the eye • \$15 copay for up to 1 routine eye exam 	<p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> • one pair of eyeglasses or contact lenses after cataract surgery • \$15 copay for exams to diagnose and treat diseases and conditions of the eye • \$15 copay for up to 1 routine eye exam • up to 1 pair of glasses or up to 1 pair of contacts <p>\$150 limit for eye wear.</p>
<p>33 Physical Exams</p>	<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>In-Network</p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam every two years.</p> <p>\$20 copay for Medicare-covered benefits</p>	<p>In-Network</p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam every two years.</p> <p>\$15 copay for Medicare-covered benefits</p>	<p>In-Network</p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam every two years.</p> <p>\$15 copay for Medicare-covered benefits.</p>

PREVENTIVE SERVICES (continued)

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>34 Health/Wellness Education</p>	<p>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.</p> <p>Each counseling attempt includes up to four face-to-face visits. You pay coinsurance and Part B deductible applies.</p>	<p>In-Network This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> • Additional Smoking Cessation • Health Club Membership/Fitness Classes 	<p>In-Network This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> • Additional Smoking Cessation • Health Club Membership/Fitness Classes 	<p>In-Network This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> • Additional Smoking Cessation • Health Club Membership/Fitness Classes
<p>35 Transportation (Routine)</p>	<p>Not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for one-way trips to plan-approved location.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for one-way trips to plan-approved location.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$75 copay for one-way trips to plan-approved location.</p>
<p>36 Acupuncture</p>	<p>Not covered.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>
<p>37 Alternative Therapy</p>	<p>Not covered.</p>	<p>Not covered.</p>	<p>Not covered.</p>	<p>In-Network Self-refer for acupuncture, naturopathy, and/or chiropractic (for manipulations not related to the spine) services for up to 12 visits per calendar year.</p>

OPTIONAL BENEFITS

Benefit Category	Original Medicare	Clear Care Basic	Clear Care Essential	Clear Care Optimal
<p>OPTIONAL SUPPLEMENTAL PACKAGE 1</p> <p>Premium and other important information</p> <p>Dental Services</p>		<p>General</p> <p>Package 1: Dental \$34 monthly premium, in addition to your \$75 monthly plan premium for the following optional benefits:</p> <ul style="list-style-type: none"> • Dental Services <p>General</p> <p>Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • up to 2 oral exams every year • up to 2 cleanings every year • up to 1 dental X-ray(s) every three years <p>\$1000 limit for preventive dental benefits every year.</p>	<p>General</p> <p>Package 1: Dental \$34 monthly premium, in addition to your \$168 monthly plan premium for the following optional benefits:</p> <ul style="list-style-type: none"> • Dental Services <p>General</p> <p>Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • up to 2 oral exams every year • up to 2 cleanings every year • up to 1 dental X-ray(s) every three years <p>\$1000 limit for preventive dental benefits every year.</p>	<p>General</p> <p>Package 1: Dental \$34 monthly premium, in addition to your \$225 monthly plan premium for the following optional benefits:</p> <ul style="list-style-type: none"> • Dental Services <p>General</p> <p>Plan offers additional comprehensive dental benefits.</p> <p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> • up to 2 oral exams every year • up to 2 cleanings every year • up to 1 dental X-ray(s) every three years <p>\$1000 limit for preventive dental benefits every year.</p>

Section III

Other benefits offered by Clear Care plans

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

CLEAR CARE

When you choose a personal physician from any of Group Health's 26 medical centers or a Group Health–contracted physician:

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
- 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

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

The Clear Care travel benefit

- **US Visitor/Traveler Benefits**

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 \$2,000 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.

- **5 additional home care visits** in addition to your current Medicare-certified home health visits.
- **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 \$34 in addition to your plan premium each month. You are covered each year for a maximum of \$1,000 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 \$25 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 \$2,500 per calendar year per member. The Optimal plan has an aggregate annual maximum of \$1,000 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 Cooperative at 1-888-901-4600 and ask for the "Evidence of Coverage."



GroupHealth