

SUMMARY OF BENEFITS

Clear Care Sound (HMO)

BENEFITS EFFECTIVE:

JAN 1, 2010 – DEC 31, 2010

COUNTIES SERVED:

King and Pierce

H5050



Thank you for your interest in our Clear Care Sound HMO plan.

Our plan is offered by Group Health Cooperative, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. If you have been diagnosed by your doctor with diabetes mellitus you may be eligible to join this plan. Please call our Customer Service department to find out if you are eligible to join. Our number is listed at the end of this introduction. This summary of benefits tells you some features of our plan. It doesn't list every service 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 Sound plan. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have diabetes mellitus you may enroll in this plan at any time but you may only leave the plan at certain times. Please call 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 Clear Care Sound 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 is the Clear Care Sound plan available?

The service area for this plan includes King and Pierce counties. You must live in one of these areas to join this plan.

Who is eligible to join Clear Care Sound?

You can join the Clear Care Sound 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 generally are not eligible to enroll in Group Health's Clear Care Sound plan unless they are already members and have been since their dialysis began. You must have been diagnosed by your doctor with diabetes mellitus to join this plan. Please call to see if you are eligible to join.

Can I choose my doctors?

Clear Care Sound has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or 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 Clear Care Sound nor the Original Medicare Plan will pay for these services.

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

The Clear Care Sound plan does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

Clear Care Sound has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a Pharmacy Network List or visit us at www.ghc.org and click on Pharmacy Services for more information. Our Customer Service number is listed at the end of this introduction.

What is a prescription drug formulary?

Clear Care Sound 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 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 my 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 Medicaid office.

What are my protections on the Clear Care Sound plan?

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

As a member of Clear Care Sound, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity

of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization for your state, Qualis Health at 1-800-949-7536.

What is the Medication Therapy Management Program?

A Medication Therapy Management (MTM) Program is a free service we may offer through the Clear Care Sound plan. 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 Clear Care Sound for more details.

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Group Health for more details.

- **Some antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis drugs:** Injectable drugs for osteoporosis for certain women with Medicare.

- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia clotting factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some oral cancer drugs:** If the same drug is available in injectable form.
- **Oral anti-nausea drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and infusion drugs** provided through DME.

Plan Ratings

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the Web, you may use the Web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at our Customer Service Department, 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 Sound 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.–8 p.m. (TTY/TDD 1-800-833-6388).

FOR MORE INFORMATION ABOUT MEDICARE

Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov 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 SOUND HMO
1 Premium and Other Important Information	<p>In 2009 the monthly Part B premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>GENERAL \$108 is the monthly plan premium in addition to your Medicare Part B premium</p> <p>IN-NETWORK \$2,500 out-of-pocket limit</p> <p>There is no limit on cost sharing for the following services:</p> <p>Supplemental Services:</p> <ul style="list-style-type: none"> • Dental Services • Hearing Services • Vision Services
2 Doctor and Hospital Choice (For more information, see Emergency—#15 and Urgently Needed Care—#16)	<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.</p> <p>Referral required for network hospitals and specialists (for certain benefits)</p> <p>OUT-OF-NETWORK Plan covers you when you travel in the U.S.</p>

Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
3 Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	<p>In 2009 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> • Days 1–60: \$1,068 deductible • Days 61–90: \$267 per day • Days 91–150: \$534 per lifetime reserve day <p>These amounts will change for 2010. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>IN-NETWORK</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> • Days 1–5: \$100 copay per day • Days 6–90: \$0 copay per day • \$0 copay for additional hospital days <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>
4 Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above)</p> <p>190-day lifetime limit in a Psychiatric Hospital</p>	<p>IN-NETWORK</p> <p>For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> • Days 1–5: \$100 copay per day • Days 6–90: \$0 copay per day <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

Section II: Summary of benefits

Inpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
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: <ul style="list-style-type: none"> • Days 1–20: \$0 per day • Days 21–100: \$133.50 per day These amounts will change for 2010. <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Days 1-10: \$0 copay per day • Days 11-100: \$25 copay per day • Plan covers up to 100 days for each benefit period. • No prior hospital stay is required.
6 Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	GENERAL Authorization rules may apply. IN-NETWORK \$0 copay for Medicare-covered 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.

Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
8 Doctor Office Visits	20% coinsurance	GENERAL See “Physical Exams” for more information. Authorization rules may apply. 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
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 \$15 copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
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 \$15 copay for each Medicare-covered visit \$15 copay for up to 12 routine visits every year Medicare-covered podiatry benefits are for medically necessary foot care.

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Outpatient care

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

Outpatient care

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
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.
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 \$15 copay for Medicare-covered urgently needed care visits
17 Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	GENERAL Authorization rules may apply. IN-NETWORK \$15 copay for Medicare-covered Occupational Therapy visits \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits

Section II: Summary of benefits

Outpatient medical services and supplies

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
18 Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	GENERAL Authorization rules may apply. IN-NETWORK \$0 copay for Medicare-covered items
19 Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	GENERAL Authorization rules may apply. IN-NETWORK \$0 of the cost for Medicare covered item
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 \$0 copay 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 • \$40 copay for Medicare-covered diagnostic radiology services • \$0 copay for Medicare-covered therapeutic radiology services

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
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.	GENERAL Authorization rules may apply. IN-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	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
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

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Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
26 Pap Smears and Pelvic Exams (for women with Medicare)	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years</p> <p>Covered once a year for women with Medicare at high risk</p> <p>20% coinsurance for pelvic exams</p>	<p>IN-NETWORK</p> <p>\$0 copay for Medicare-covered Pap smears and pelvic exams</p>
27 Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<p>20% coinsurance for the digital rectal exam</p> <p>\$0 for the PSA test; 20% coinsurance for other related services</p> <p>Covered once a year for all men with Medicare over age 50</p>	<p>GENERAL</p> <p>Authorization rules may apply.</p> <p>IN-NETWORK</p> <p>\$0 copay for Medicare-covered prostate cancer screening</p>
28 End Stage Renal Disease	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant), when referred by a doctor. These services can be given by registered dietitians or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>GENERAL</p> <p>Authorization rules may apply.</p> <p>IN-NETWORK</p> <p>\$0 copay for renal dialysis</p> <p>\$0 copay for nutrition therapy for End Stage Renal Disease</p>

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs	<p>Most drugs are not covered by Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>GENERAL</p> <p>\$0 copay for Part B covered drugs</p> <p>Drugs covered under Medicare Part C</p> <p>GENERAL</p> <p>\$0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.</p> <p>Drugs covered under Medicare Part D</p> <p>GENERAL</p> <p>This plan uses a formulary.</p> <p>The plan will send you the formulary. You can also see the formulary at www.ghc.org by clicking on Pharmacy Services.</p> <p>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).</p> <p>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>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> IN-NETWORK		<p>Total yearly drug costs are the total drug costs paid by both you and the plan. Some drugs have quantity limits. Your provider must get prior authorization from Clear Care Sound (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's Web site, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a tier exception for a drug in this plan and Clear Care Sound approves the exception, you will pay the nonpreferred cost share.</p>

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> IN-NETWORK		<p>IN-NETWORK \$0 yearly deductible</p> <hr/> <p>INITIAL COVERAGE You pay the following until total yearly drug costs reach \$2,830:</p> <p>Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (30-day) supply of drugs in this tier • \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (30-day) supply of drugs in this tier • \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Nonpreferred</p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs in this tier • 50% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

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Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> IN-NETWORK		<p>LONG TERM CARE PHARMACY</p> <p>Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Nonpreferred</p> <ul style="list-style-type: none"> 50% coinsurance for a one-month (31-day) supply of drugs in this tier <hr/> <p>MAIL ORDER</p> <p>Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (30-day) supply of drugs in this tier \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Preferred Brand</p> <ul style="list-style-type: none"> \$10 copay for a one-month (30-day) supply of drugs in this tier \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Nonpreferred</p> <ul style="list-style-type: none"> 50% coinsurance for a one-month (30-day) supply of drugs 50% coinsurance for a one-month (90-day) supply of drugs <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> IN-NETWORK		<p>COVERAGE GAP</p> <p>The plan covers many generics (65-99% of formulary generic drugs) through the coverage gap. You pay the following:</p> <p>Retail Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (30-day) supply of drugs in this tier \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (31-day) supply of drugs in this tier <p>Mail Order Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (30-day) supply of drugs in this tier \$30 copay for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>For all other covered drugs, after your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p>

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Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i>		CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: <ul style="list-style-type: none"> • \$2.50 copay for generic (including brand drugs treated as generic) and \$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 Clear Care Sound (HMO).

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> OUT-OF-NETWORK		OUT-OF-NETWORK INITIAL COVERAGE You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830: <p>Preferred Generic</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (30-day) supply of drugs in this tier <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (30-day) supply of drugs in this tier <p>Nonpreferred</p> <ul style="list-style-type: none"> • 50% coinsurance for a one-month (30-day) supply of drugs in this tier

Section II: Summary of benefits

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> OUT-OF-NETWORK		<p>OUT-OF-NETWORK COVERAGE GAP You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic</p> <ul style="list-style-type: none"> \$10 copay for a one-month (30-day) supply of drugs in this tier <p>Preferred Brand After your total yearly drug costs in this tier reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Clear Care Sound for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Clear Care Sound so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Nonpreferred After your total yearly drug costs in this tier reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Clear Care Sound for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Clear Care Sound so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
29 Prescription Drugs <i>Continued</i> OUT-OF-NETWORK		<p>OUT-OF-NETWORK CATASTROPHIC COVERAGE After your yearly out-of-pocket drug costs reach \$4550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> \$2.50 copay for generic (including brand drugs treated as generic) and \$6.30 copay for all other drugs, or 5% coinsurance
30 Dental Services	Preventive dental services (such as cleaning) are not covered.	<p>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")</p> <p>0% of the cost for Medicare-covered dental benefits</p>
31 Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams	<p>IN-NETWORK Hearing aids not covered</p> <ul style="list-style-type: none"> \$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

Section II: Summary of benefits

Preventive services

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
32 Vision Services	<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> <ul style="list-style-type: none"> • \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery • \$15 copay for exams to diagnose and treat diseases and conditions of the eye • \$0 copay for up to 1 routine eye exam every year
33 Physical Exams	<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 year</p> <p>\$15 copay for Medicare-covered benefits</p>
34 Health/Wellness Education	<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</p> <p>This plan covers health/wellness education benefits:</p> <ul style="list-style-type: none"> • Additional smoking cessation • Consulting Nurse Service • Health Club Membership • Fitness Classes • \$0 copay for each Medicare-covered smoking cessation counseling session.
35 Transportation (Routine)	Not covered	<p>GENERAL</p> <p>Authorization rules may apply</p> <p>IN-NETWORK</p> <p>\$150 copay for one-way trips to plan-approved location</p>
36 Acupuncture	Not covered	<p>IN-NETWORK</p> <p>This plan does not cover Acupuncture.</p>

Optional benefits

BENEFIT CATEGORY	ORIGINAL MEDICARE	CLEAR CARE SOUND HMO
<p>Optional Supplemental Package 1</p> <p>Premium and other important information</p> <p>Dental Services</p>		<p>GENERAL</p> <p>Package 1: Dental</p> <p>\$48 monthly premium, in addition to your \$108 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:</p> <ul style="list-style-type: none"> • Dental Services <p>\$1,500 limit every year for these benefits</p> <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 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 <p>\$1500 limit for dental benefits every year</p>

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

YOU CAN

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

YOU'LL GET

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

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 \$3,000 per member per calendar year. Plan pays 80% of Medicare allowable reimbursement schedules for Medicare covered services only. Member is responsible for all Medicare inpatient and outpatient deductibles and coinsurances.

Additional information about covered benefits found in Section II

Dental Benefits

Note: If you have elected to purchase Dental Benefits, your monthly premium will be \$48 in addition to your plan premium each month.

You are covered each year for a maximum of \$1,500 for COMBINED preventive and/or comprehensive benefit for ALL plan covered dental services. Covered preventive services paid at 100% of Washington Dental Service (WDS) approved fee schedule when you go to an in-network PPO provider. WDS pays at 80% when you go to an out-of-network provider. Restorative covered services paid at 80% of WDS approved fee schedule when you go to an in-network PPO Provider. WDS pays at 70% when you go to an out-of-network provider. Coverage for denture adjustments and relines covered services paid at 50% of Washington Dental Service (WDS) approved fee schedule when you go to an in-network PPO Provider. WDS pays at 40% when you go to an out-of-network provider. A \$100 annual deductible applies to dental services except for preventive dental care.

Annual Plan Care Visit and Annual Retinopathy Screening

The Clear Care Sound plan also includes an Annual Plan Care visit and an Annual Retinopathy screening. There is no copay for either of these annual services.

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 listed in this summary of benefits, hospital emergency room visits, ambulance/transportation services, inpatient hospital stays, and inpatient mental health care stays, are limited to an aggregate annual maximum of \$1,500 per calendar year per member.



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