Summary of Benefits

Group Health Options Clear Care® Prestige (PPO)

BENEFITS EFFECTIVE:
JANUARY 1, 2013– DECEMBER 31, 2013

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GroupHealth®

Introduction to the Summary of Benefits Report

for **GROUP HEALTH OPTIONS CLEAR CARE PRESTIGE (PPO)**

JANUARY 1, 2013 – DECEMBER 31, 2013

ALL COUNTIES SERVED BY GROUP HEALTH OPTIONS, INC.

Thank you for your interest in Group Health Options Clear Care Prestige (PPO). Our plan is offered by GROUP HEALTH OPTIONS/Group Health Options, Inc., a Medicare Advantage Preferred Provider Organization (PPO) that contracts with the Federal government. 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 Options Clear Care Prestige (PPO) 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 Options Clear Care Prestige (PPO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Group Health Options Clear Care Prestige (PPO) at the number listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information. TTY/TDD users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Group Health Options Clear Care Prestige (PPO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS GROUP HEALTH OPTIONS CLEAR CARE PRESTIGE (PPO) AND AVAILABLE?

The service area for this plan includes: Benton, Clallam* (98382, 98362, 98368, 98363), Franklin, Jefferson* (98339, 98325, 98358), and Yakima Counties, WA. You must live in one of these areas to join the plan.

* denotes partial county

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WHO IS ELIGIBLE TO JOIN GROUP HEALTH OPTIONS CLEAR CARE PRESTIGE (PPO)?

You can join Group Health Options Clear Care Prestige (PPO) 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 generally not eligible to enroll in Group Health Options Clear Care Prestige (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Group Health Options Clear Care Prestige (PPO) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at **http://www.ghc.org/provider/index.jhtml**. 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?

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

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

Group Health Options Clear Care Prestige (PPO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at **www.ghc.org/medicare.** Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Group Health Options Clear Care Prestige (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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WHAT IS A PRESCRIPTION DRUG FORMULARY?

Group Group Health Options Clear Care Prestige (PPO) 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 members before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **https://www1.ghc.org/medicare/formulary.**

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

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**, 24 hours a day/7 days a week; and see **www.medicare.gov** 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- The Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call **1-800-325-0778**; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

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

As a member of Group Health Options Clear Care Prestige (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Group Health Options Clear Care Prestige (PPO) 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 Options Clear Care Prestige (PPO) 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 some women.
- **Erythropoietin (Epoetin Alfa or Epogen®)**: By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare certified facility and was paid for by Medicare, or by a private insurance company that was the primary payer for Medicare Part A coverage.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs** administered through Durable Medical Equipment.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on **www.medicare.gov** and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

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Please call Group Health Options, Inc. for more information about Group Health Options Clear Care Prestige (PPO).

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

Customer Service Hours for October 1–February 14:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
8:00 a.m.–8:00 p.m. Pacific

Customer Service Hours for February 15–September 30:
Monday, Tuesday, Wednesday, Thursday, Friday,
8:00 a.m.–8:00 p.m. Pacific

Current members should call toll-free **(888) 901-4600** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD **(800) 833-6388**)

Prospective members should call toll-free **(800) 446-8882** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD **(800) 833-6388**)

Current members should call locally **(206) 901-4600** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD **(800) 833-6388**)

Prospective members should call locally **(800) 446-8882** for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD **(800) 833-6388**)

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

Or, visit **www.medicare.gov** on the web.

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

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

Este documento puede estar disponible en un idioma que no sea inglés. Para obtener más información, llame al servicio al cliente en el número de teléfono que aparece arriba.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
IMPORTANT INFORMATION		
1–Premium and Other Important Information	In 2012 the monthly Part B Premium was $99.90 and may change for 2013 and the annual Part B deductible amount was $140 and may change for 2013. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048.** You may also call Social Security at **1-800-772-1213.** TTY users should call **1-800-325-0778.**	**General** **$103** monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048.** You may also call Social Security at **1-800-772-1213.** TTY users should call **1-800-325-0778.** Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on **www.medicare.gov** for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
IMPORTANT INFORMATION		
		To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit **www.medicare.gov/physician** or **www.medicare.gov/supplier.** You can also call **1-800-MEDICARE,** or ask your physician, provider, or supplier if they accept assignment. **In-Network** $3,200 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit. **In and Out-of-Network** $3,200 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.
2–Doctor and Hospital Choice (For more information, see Emergency Care – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** Referral required for network hospitals and specialists (for certain benefits). **In and Out-of-Network** You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
SUMMARY OF BENEFITS		
INPATIENT CARE		
3–Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2012 the amounts for each benefit period were: Days 1–60: $1156 deductible Days 61–90: $289 per day Days 91–150: $578 per lifetime reserve day These amounts may change for 2013. Call **1-800-MEDICARE (1-800-633-4227)** for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**In-Network** No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1–5: $200 copay per day Days 6–90: $0 copay per day $0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** For hospital stays: Days 1–5: $400 copay per day Days 6–90: $0 copay per day

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
4–Inpatient Mental Health Care	In 2012 the amounts for each benefit period were: Days 1–60: $1156 deductible Days 61–90: $289 per day Days 91–150: $578 per lifetime reserve day These amounts may change for 2013. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-Network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. For Medicare-covered hospital stays: Days 1–5: $200 copay per day Days 6–90: $0 copay per day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. **Out-of-Network** For hospital stays: Days 1–5: $400 copay per day Days 6–90: $0 copay per day

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
5–Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2012 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1–20: $0 per day Days 21–100: $144.50 per day These amounts may change for 2013. 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** Plan covers up to 100 days each benefit period No prior hospital stay is required For SNF stays: Days 1–100: $50 copay per day **Out-of-Network** For each SNF stay: Days 1–100: $75 copay per SNF day
6—Home Health Care (Includes medically necessary intermittent skill 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 **Out-of-Network** 20% of the cost for Medicare-covered home health visits

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
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. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE		
8–Doctor Office Visits	20% coinsurance	**In-Network** $20 copay for each Medicare-covered primary care doctor visit. $45 copay for each Medicare-covered specialist visit. **Out-of-Network** $35 copay for each Medicare-covered primary care doctor visit. $60 copay for each Medicare-covered specialist visit
9–Chiropractic Services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-Network** $20 copay for each Medicare-covered chiropractic 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. **Out-of-Network** $35 copay for Medicare-covered chiropractic visits.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
10–Podiatry Services	Supplemental 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** $45 copay for each Medicare-covered podiatry visit. Medicare-covered podiatry visits are for medically-necessary foot care. **Out-of-Network** $60 copay for Medicare-covered podiatry visits
11–Outpatient Mental Health Care	35% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $0 copay for Medicare-covered partial hospitalization program services **Out-of-Network** $35 copay for Medicare-covered Mental Health visits with a psychiatrist $35 copay for Medicare-covered Mental Health visits $0 copay for Medicare-covered partial hospitalization program services

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
12–Outpatient Substance Abuse Care	20% coinsurance	**General** Authorization rules may apply. **In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits $20 copay for Medicare-covered group substance abuse outpatient treatment visits **Out-of-Network** $35 copay Medicare-covered substance abuse outpatient treatment visits
13–Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**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 **Out-of-Network** $400 copay for Medicare-covered outpatient hospital facility visits $400 copay for Medicare-covered ambulatory surgical center visits
14–Ambulance Services (medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $0 to $150 copay for Medicare-covered ambulance benefits. **Out-of-Network** $150 copay for Medicare-covered ambulance benefits.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
15–Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits Worldwide coverage If you are admitted to the hospital within 1-day for the same condition, you pay $0 for the emergency room visit.
16–Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $20 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** $20 copay for Medicare-covered Occupational Therapy visits $20 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits **Out-of-Network** $35 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits $35 copay for Medicare-covered Occupational Therapy visits.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18–Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment You may pay less if you purchase these items from the plan's preferred manufacturers/vendors. Contact the plan for a list of non-preferred and preferred manufacturers/vendors. **Out-of-Network** 30% of the cost for Medicare-covered durable medical equipment
19–Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices **Out-of-Network** 30% of the cost for Medicare-covered prosthetic devices.

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20–Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**In-Network** $0 copay for Medicare-covered Diabetes self-management training 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts **Out-of-Network** 30% of the cost for Medicare-covered Diabetes monitoring supplies 30% of the cost for Medicare-covered Therapeutic shoes or inserts $0 copay for Medicare-covered Diabetes self-management training
21–Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**In-Network** $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests • X-rays • therapeutic radiology services $75 copay for Medicare-covered diagnostic radiology services (not including X-rays) **Out-of-Network** $150 copay for Medicare-covered diagnostic radiology services $0 copay for Medicare-covered therapeutic radiology services $0 copay for Medicare-covered outpatient X-rays $0 copay for Medicare-covered diagnostic procedures, tests, and lab services

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22–Cardiac and Pulmonary Rehabilitation Services	20% coinsurance for Cardiac Rehabilitation services 20% coinsurance for Pulmonary Rehabilitation services 20% coinsurance for Intensive Cardiac Rehabilitation services. This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**In-Network** $20 copay for Medicare-covered Cardiac Rehabilitation Services $20 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $20 copay for Medicare-covered Pulmonary Rehabilitation Services **Out-of-Network** $35 copay for Medicare-covered Cardiac Rehabilitation Services $35 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $35 copay for Medicare-covered Pulmonary Rehabilitation Services
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS		
23–Preventive Services, Wellness/Education and other Supplemental Benefit Programs	No coinsurance, copayment or deductible for the following: • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. **In-Network** The plan covers the following supplemental education/wellness programs: • Additional Smoking and Tobacco Use Cessation Visits • Nursing Hotline **Out-of-Network** $0 copay for Medicare-covered preventive services $0 copay for supplemental education/wellness programs

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	• HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35–39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information • Prostate Cancer Screening	

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
	• Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. • Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse • Screening for depression in adults • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs • Intensive behavioral counseling for Cardiovascular Disease (bi-annual) • Intensive behavioral therapy for obesity • Welcome to Medicare Preventive Visits (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Preventive Visits or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.	

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
24–Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** $0 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services **Out-of-Network** $0 copay for Medicare-covered kidney disease education services $0 copay for Medicare-covered renal dialysis
PRESCRIPTION DRUG BENEFITS		
25–Outpatient Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs Covered under Medicare Part B** **General** $0 copay for Medicare Part B drugs. $0 copay for Medicare Part B drugs out-of-network. **Home Infusion Drugs, Supplies and Services** **General** $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **https://www1.ghc. org/medicare/formulary** on the web.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		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) providers. Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details. Total yearly drug costs are the total drug costs paid by both you and a Part D plan. Some drugs have quantity limits. Your provider must get prior authorization from Group Health Options Clear Care Prestige (PPO) for certain drugs.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. 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. You pay $0 the first time you fill a prescription for certain drugs. These drugs will be listed as "free first fill" on the plan's website, formulary, printed materials, and on the Medicare Prescription Drug Plan Finder on **Medicare.gov.** If you request a formulary exception for a drug and Group Health Options Clear Care Prestige (PPO) approves the exception, you will pay Tier 4: Non-Preferred Brand cost sharing for that drug. **In-Network** $325 annual deductible.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach $2,970: **Retail Pharmacy** Tier 1: Preferred Generic • $3 copay for a one-month (30-day) supply of drugs in this tier • $9 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic • $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 Tier 3: Preferred Brand • $14 copay for a one-month (30-day) supply of drugs in this tier • $42 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand • 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

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		Long Term Care Pharmacy Tier 1: Preferred Generic • $3 copay for a one-month (31-day) supply of generic drugs in this tier Tier 2: Non-Preferred Generic • $10 copay for a one-month (31-day) supply of generic drugs in this tier Tier 3: Preferred Brand • $14 copay for a one-month (31-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/ collection when less than a one-month supply is dispensed. Tier 4: Non-Preferred Brand • 50% coinsurance for a one-month (31-day) supply of drugs in this tier Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/ collection when less than a one-month supply is dispensed

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		Mail Order Tier 1: Preferred Generic • $3 copay for a one-month (30-day) supply of drugs in this tier • $9 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic • $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 Tier 3: Preferred Brand • $14 copay for a one-month (30-day) supply of drugs in this tier • $42 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand • 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 **Coverage Gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs. **Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Group Health Options Clear Care Prestige (PPO). **Out-of-Network Initial Coverage** After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach $2,970: Tier 1: Preferred Generic • $3 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic • $10 copay for a one-month (30-day) supply of drugs in this tier

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
		Tier 3: Preferred Brand • $14 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Non-Preferred Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier **Out-of-Network Coverage Gap** You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copay for all other drugs.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
26–Dental Services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered dental benefits This plan covers some preventive dental benefits for an extra cost (see "Optional Supplemental Benefits.") **Out-of-Network** $0 copay for Medicare-covered comprehensive dental benefits
27–Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** Hearing aids not covered. $20 copay for Medicare-covered diagnostic hearing exams $20 copay for up to 1 supplemental routine hearing exam(s) every year **Out-of-Network** $35 copay for Medicare-covered diagnostic hearing exams

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
28–Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** $0 copay for • one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery • $20 to $45 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. • $20 to $45 copay for up to 1 supplemental routine eye exam (s) every year **Out-of-Network** • $0 copay for Medicare-covered eye wear • $35 to $60 copay for Medicare-covered eye exams • $35 to $60 copay for supplemental eye exams
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**In-Network** This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	**In-Network** This plan does not cover Acupuncture.

Benefit Category	Original Medicare	Group Health Options Clear Care Prestige (PPO)
Optional Benefits		
OPTIONAL SUPPLEMENTAL PACKAGE # 1		
Premium and Other Important Information		**General** **Package: 1—Clear Care Dental:** **$51** monthly premium, in addition to your **$103** monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Preventive Dental • Comprehensive Dental $1,500 plan coverage limit every year for these benefits.
Dental Services		**In-Network** • 0% of the cost for up to 2 cleaning(s) every year • 0% of the cost for up to 2 fluoride treatment(s) every year • 0% of the cost for up to 2 oral exam(s) every year • 0% of the cost for up to 2 dental x-ray(s) every year **Out-of-Network** • 20% of the cost for preventive dental services • 30% to 60% of the cost for comprehensive dental services **In and Out-of-Network** $1,500 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits. Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.

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Customer Service

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