MEDICARE
ADVANTAGE
HMO

GroupHealth®

Group Health Cooperative Medicare Advantage HMO

# Summary of Benefits

- Group Health
  Medicare Advantage Basic (HMO)
- Group Health
  Medicare Advantage Vital (HMO)
- Group Health
  Medicare Advantage Essential (HMO)
- Group Health
  Medicare Advantage Optimal (HMO)

**BENEFITS EFFECTIVE:**
JANUARY 1, 2015–DECEMBER 31, 2015

H5050

**Available in King, Kitsap, Lewis, Pierce, Snohomish, and Thurston counties, and parts of Grays Harbor and Mason counties**

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## YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Group Health Cooperative (HMO)**).

## TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Group Health Cooperative (HMO)** covers and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **http://www.medicare.gov**.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **http://www.medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

## SECTIONS IN THIS BOOKLET

- Things to Know About **Group Health Cooperative (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Optional Benefits (you must pay an extra premium for these benefits)
- Additional Information About Group Health Cooperative (HMO)

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at

- Current members should call **206-901-4600** or **1-888-901-4600**. (TTY/TDD **1-800-833-6388** or **711)**
- Prospective members should call **1-800-446-8882**. (TTY/TDD **1-800-833-6388** or **711)**

## THINGS TO KNOW ABOUT GROUP HEALTH COOPERATIVE (HMO)

### Hours of Operation

From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time.

From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time.

### Group Health Cooperative (HMO) Phone Numbers and Website

- If you are a member of this plan, call **206-901-4600** or **1-888-901-4600**. (TTY/TDD **1-800-833-6388** or **711)**
- If you are not a member of this plan, call **1-800-446-8882**. (TTY/TDD **1-800-833-6388** or **711)**
- Our website: **medicare.ghc.org**

**Who can join?**

To join **Group Health Cooperative (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

**Basic:** Our service area includes the following counties in Washington: Grays Harbor* (ZIP codes 98541, 98557, 98559, 98568), Island, King, Kitsap, Lewis, Mason* (ZIP codes 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592), Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, and Whatcom.

**Vital, Essential, and Optimal:** Grays Harbor* (ZIP codes 98541, 98557, 98559, 98568), King, Kitsap, Lewis, Mason* (ZIP codes 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592), Pierce, Snohomish, and Thurston.

* denotes partial county

**Which doctors, hospitals, and pharmacies can I use?**

**Group Health Cooperative (HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider and pharmacy directory at our website **(medicare.ghc.org)**.

Or, call us and we will send you a copy of the provider directory.

**What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers—and more.

**Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.

**Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

**Group Health Cooperative Basic (HMO)** covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

**Group Health Cooperative Vital, Essential, and Optimal (HMO)** plans cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **medicare.ghc.org/formulary**.

Or, call us and we will send you a copy of the formulary.

**How will I determine my drug costs?**

Our Vital, Essential, and Optimal plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Group Health Cooperative for details.

## MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

| Benefit | Basic |
|---|---|
| **How much is the monthly premium?** | $50 per month. In addition, you must keep paying your Medicare Part B premium. |
| **How much is the deductible?** | This plan does not have a deductible. |
| **Is there any limit on how much I will pay for my covered services?** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>$3,000 for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums. |
| **Is there a limit on how much the plan will pay?** | No. There are no limits on how much our plan will pay. |

Group Health Cooperative is an HMO plan with a Medicare contract.
Enrollment in Group Health HMO depends on contract renewal.

| Vital | Essential | Optimal |
|---|---|---|
| $27 per month. In addition, you must keep paying your Medicare Part B premium. | $113 per month. In addition, you must keep paying your Medicare Part B premium. | $253 per month. In addition, you must keep paying your Medicare Part B premium. |
| This plan does not have a deductible. | This plan does not have a deductible. | This plan does not have a deductible. |
| Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>$6,700 for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>$4,500 for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>$2,000 for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| No. There are no limits on how much our plan will pay. | No. There are no limits on how much our plan will pay. | No. There are no limits on how much our plan will pay. |

## COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE: SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.
SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

| Benefit | Basic |
|---|---|
| **OUTPATIENT CARE AND SERVICES** | |
| **Acupuncture and Other Alternative Therapies** | Not covered |
| **Ambulance[1]** | $0–150 copay, depending on the service<br>Hospital to hospital ambulance transfers initiated by Group Health: You pay nothing |
| **Chiropractic Care** | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay |
| **Dental Services[1,2]** | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $35 copay |
| **Diabetes Supplies and Services[1,2]** | Diabetes monitoring supplies: 20% of the cost<br>Diabetes self-management training: You pay nothing<br>Therapeutic shoes or inserts: 20% of the cost |

| Vital | Essential | Optimal |
|---|---|---|
| Not covered | Not covered | For up to 12 visit(s): $10 copay<br>Our plan covers acupuncture, naturopathy and/or chiropractic non-spinal manipulation services up to 12 visits combined per calendar year.<br>Services must be provided by a state licensed/certified provider only. |
| $0–250 copay, depending on the service<br>Hospital to hospital ambulance transfers initiated by Group Health: You pay nothing | $0–150 copay, depending on the service<br>Hospital to hospital ambulance transfers initiated by Group Health: You pay nothing | $0–100 copay, depending on the service<br>Hospital to hospital ambulance transfers initiated by Group Health: You pay nothing |
| Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $10 copay |
| Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $50 copay | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $35 copay | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing |
| Diabetes monitoring supplies: 20% of the cost<br>Diabetes self-management training: You pay nothing<br>Therapeutic shoes or inserts: 20% of the cost | Diabetes monitoring supplies: 20% of the cost<br>Diabetes self-management training: You pay nothing<br>Therapeutic shoes or inserts: 20% of the cost | Diabetes monitoring supplies: 20% of the cost<br>Diabetes self-management training: You pay nothing<br>Therapeutic shoes or inserts: 20% of the cost |

## Section II – Summary of Benefits

| Benefit | Basic |
|---|---|
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**[1,2] | Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost<br>Diagnostic tests and procedures: You pay nothing<br>Lab services: You pay nothing<br>Outpatient x-rays: You pay nothing<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost |
| **Doctor's Office Visits**[1,2] | Primary care physician visit: $10 copay<br>Specialist visit: $35 copay |
| **Durable Medical Equipment** (wheelchairs, oxygen, etc.)[1] | 20% of the cost<br>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. |
| **Emergency Care** | $65 copay<br>If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Foot Care** (podiatry services)[1,2] | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 copay |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues: $10 copay<br>Routine hearing exam (for up to 1 every year): $10 copay |
| **Home Health Care**[1,2] | You pay nothing |

| Vital | Essential | Optimal |
|---|---|---|
| Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost<br>Diagnostic tests and procedures: 20% of the cost<br>Lab services: 20% of the cost<br>Outpatient x-rays: 20% of the cost<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost | Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost<br>Diagnostic tests and procedures: You pay nothing<br>Lab services: You pay nothing<br>Outpatient x-rays: You pay nothing<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost | Diagnostic radiology services (such as MRIs, CT scans): $25 copay<br>Diagnostic tests and procedures: You pay nothing<br>Lab services: You pay nothing<br>Outpatient x-rays: You pay nothing<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost |
| Primary care physician visit: $10 copay<br>Specialist visit: $50 copay | Primary care physician visit: $10 copay<br>Specialist visit: $35 copay | Primary care physician visit: $10 copay<br>Specialist visit: $20 copay |
| 20% of the cost<br>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. | 20% of the cost<br>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. | 20% of the cost<br>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. |
| $65 copay<br>If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | $65 copay<br>If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | $65 copay<br>If you are admitted to the hospital within 1 day, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $50 copay | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 copay | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $20 copay |
| Exam to diagnose and treat hearing and balance issues: $50 copay<br>Routine hearing exam (for up to 1 every year): $50 copay | Exam to diagnose and treat hearing and balance issues: $10 copay<br>Routine hearing exam (for up to 1 every year): $10 copay | Exam to diagnose and treat hearing and balance issues: $10 copay<br>Routine hearing exam (for up to 1 every year): $10 copay<br>Hearing aid fitting/evaluation (for up to 1 every year): You pay nothing<br>Hearing aid: You pay nothing<br>Our plan pays up to $500 every year for hearing aids. |
| You pay nothing | You pay nothing | You pay nothing |

| Benefit | Basic |
|---|---|
| **Mental Health Care**[1,2] | Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>$250 copay per day for days 1 through 4<br>You pay nothing per day for days 5 through 90<br>Outpatient group therapy visit: $35 copay<br>Outpatient individual therapy visit: $35 copay<br>Medicare-covered partial hospitalization program services: You pay nothing |
| **Outpatient Rehabilitation**[1,2] | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $35 copay<br>Occupational therapy visit: $35 copay<br>Physical therapy and speech and language therapy visit: $35 copay |
| **Outpatient Substance Abuse**[1] | Group therapy visit: $35 copay<br>Individual therapy visit: $35 copay |

| Vital | Essential | Optimal |
|---|---|---|
| Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>$350 copay per day for days 1 through 4<br>You pay nothing per day for days 5 through 90<br>Outpatient group therapy visit: $40 copay<br>Outpatient individual therapy visit: $40 copay<br>Medicare-covered partial hospitalization program services: You pay nothing | Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>$250 copay per day for days 1 through 4<br>You pay nothing per day for days 5 through 90<br>Outpatient group therapy visit: $35 copay<br>Outpatient individual therapy visit: $35 copay<br>Medicare-covered partial hospitalization program services: You pay nothing | Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>$100 copay per day for days 1 through 2<br>You pay nothing per day for days 3 through 90<br>Outpatient group therapy visit: $10 copay<br>Outpatient individual therapy visit: $10 copay<br>Medicare-covered partial hospitalization program services: You pay nothing |
| Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $40 copay<br>Occupational therapy visit: $40 copay<br>Physical therapy and speech and language therapy visit: $40 copay | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $35 copay<br>Occupational therapy visit: $35 copay<br>Physical therapy and speech and language therapy visit: $35 copay | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $10 copay<br>Occupational therapy visit: $10 copay<br>Physical therapy and speech and language therapy visit: $10 copay |
| Group therapy visit: $50 copay<br>Individual therapy visit: $50 copay | Group therapy visit: $35 copay<br>Individual therapy visit: $35 copay | Group therapy visit: $20 copay<br>Individual therapy visit: $20 copay |

## Section II – Summary of Benefits

| Benefit | Basic |
|---|---|
| **Outpatient Surgery**[1,2] | Ambulatory surgical center: $200 copay<br>Outpatient hospital: $200 copay |
| **Over-the-Counter Items** | Not Covered |
| **Prosthetic Devices** (braces, artificial limbs, etc.)[1] | Prosthetic devices: 20% of the cost<br>Related medical supplies: 20% of the cost |
| **Renal Dialysis**[2] | 20% of the cost<br>Medicare-covered kidney disease education services: You pay nothing |
| **Transportation** | Not covered |
| **Urgent Care** | $25 copay |
| **Vision Services**[2] | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10–35 copay, depending on the service<br>Routine eye exam (for up to 1 every year): $10–35 copay, depending on the service<br>Eyeglasses or contact lenses after cataract surgery: You pay nothing |

| Vital | Essential | Optimal |
|---|---|---|
| Ambulatory surgical center:<br>20% of the cost<br>Outpatient hospital:<br>20% of the cost | Ambulatory surgical center:<br>$200 copay<br>Outpatient hospital:<br>$200 copay | Ambulatory surgical center:<br>$100 copay<br>Outpatient hospital:<br>$100 copay |
| Not Covered | Not Covered | Not Covered |
| Prosthetic devices: 20% of the cost<br>Related medical supplies:<br>20% of the cost | Prosthetic devices: 20% of the cost<br>Related medical supplies:<br>20% of the cost | Prosthetic devices: 20% of the cost<br>Related medical supplies:<br>20% of the cost |
| 20% of the cost<br>Medicare-covered kidney disease education services: You pay nothing | 20% of the cost<br>Medicare-covered kidney disease education services: You pay nothing | 20% of the cost<br>Medicare-covered kidney disease education services: You pay nothing |
| Not covered | Not covered | You pay nothing<br>Our plan covers up to 12 one-way trips(s) to a plan-approved location every year.<br>Transportation benefit is for health related purposes only. |
| $25 copay | $25 copay | $25 copay |
| Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10–50 copay, depending on the service<br>Routine eye exam (for up to 1 every year): $10–50 copay, depending on the service<br>Eyeglasses or contact lenses after cataract surgery: You pay nothing | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10–35 copay, depending on the service<br>Routine eye exam (for up to 1 every year): $10–35 copay, depending on the service<br>Eyeglasses or contact lenses after cataract surgery: You pay nothing | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $10–20 copay, depending on the service<br>Routine eye exam (for up to 1 every year): $10–20 copay, depending on the service<br>Contact lenses (for up to 1 every year): You pay nothing<br>Eyeglasses (frames and lenses) (for up to 1 every year):<br>You pay nothing<br>Eyeglasses or contact lenses after cataract surgery: You pay nothing<br>Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses). |

| Benefit | Basic |
|---|---|
| **Preventive Care**[1,2] | You pay nothing<br><br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. |

| Vital | Optimal | Essential |
|---|---|---|
| You pay nothing<br><br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. | You pay nothing<br><br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. | You pay nothing<br><br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. |

| Benefit | Basic |
|---|---|
| **INPATIENT CARE** | |
| **Inpatient Hospital Care**[1,2] | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• $250 copay per day for days 1 through 4<br>• You pay nothing per day for days 5 through 90<br>• You pay nothing per day for days 91 and beyond |
| **Inpatient Mental Health Care** | For inpatient mental health care, see the "Mental Health Care" section of this booklet. |
| **Skilled Nursing Facility (SNF)**[1,2] | Our plan covers up to 100 days in a SNF.<br>• $25 copay per day for days 1 through 20<br>• $50 copay per day for days 21 through 100 |
| **PRESCRIPTION DRUG BENEFITS** | |
| **How much do I pay?** | For Part B drugs such as chemotherapy drugs[1]: 20% of the cost<br>Other Part B drugs[1]: 20% of the cost<br>Our plan does not cover Part D prescription drug. |

| Vital | Essential | Optimal |
|---|---|---|
| | | |
| Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• $350 copay per day for days 1 through 4<br>• You pay nothing per day for days 5 through 90<br>• You pay nothing per day for days 91 and beyond | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• $250 copay per day for days 1 through 4<br>• You pay nothing per day for days 5 through 90<br>• You pay nothing per day for days 91 and beyond | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• $100 copay per day for days 1 through 2<br>• You pay nothing per day for days 3 through 90<br>• You pay nothing per day for days 91 and beyond |
| For inpatient mental health care, see the "Mental Health Care" section of this booklet. | For inpatient mental health care, see the "Mental Health Care" section of this booklet. | For inpatient mental health care, see the "Mental Health Care" section of this booklet. |
| Our plan covers up to 100 days in a SNF.<br>• You pay nothing per day for days 1 through 20<br>• $150 copay per day for days 21 through 100 | Our plan covers up to 100 days in a SNF.<br>• You pay nothing per day for days 1 through 20<br>• $100 copay per day for days 21 through 100 | Our plan covers up to 100 days in a SNF.<br>• You pay nothing per day for days 1 through 20<br>• $25 copay per day for days 21 through 100 |

| | | |
|---|---|---|
| For Part B drugs such as chemotherapy drugs[1]: 20% of the cost<br>Other Part B drugs[1]: 20% of the cost<br>Home infusion drugs, supplies, and services: You pay nothing | For Part B drugs such as chemotherapy drugs[1]: 20% of the cost<br>Other Part B drugs[1]: 20% of the cost<br>Home infusion drugs, supplies, and services: You pay nothing | For Part B drugs such as chemotherapy drugs[1]: 20% of the cost<br>Other Part B drugs[1]: 20% of the cost<br>Home infusion drugs, supplies, and services: You pay nothing |

**PRESCRIPTION DRUG BENEFITS**

## Group Health Cooperative Basic (HMO)

**Initial Coverage**

Our plan does not cover Part D prescription drug.

## Group Health Cooperative Vital, Essential, and Optimal (HMO)

**Initial Coverage**

You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

**Standard Retail Cost-Sharing**

| Tier | One-month supply | Two-month supply | Three-month supply |
|---|---|---|---|
| **Tier 1** (Preferred Generic) | $4 copay | $8 copay | $12 copay |
| **Tier 2** (Non-Preferred Generic) | $21 copay | $42 copay | $63 copay |
| **Tier 3** (Preferred Brand) | $45 copay | $90 copay | $135 copay |
| **Tier 4** (Non-Preferred Brand) | $95 copay | $190 copay | $285 copay |
| **Tier 5** (Specialty Tier) | 33% of the cost | Not Offered | Not Offered |

**Standard Mail Order Cost-Sharing**

| Tier | One-month supply | Two-month supply | Three-month supply |
|---|---|---|---|
| **Tier 1** (Preferred Generic) | $4 copay | $8 copay | $12 copay |
| **Tier 2** (Non-Preferred Generic) | $21 copay | $42 copay | $63 copay |
| **Tier 3** (Preferred Brand) | $45 copay | $90 copay | $135 copay |
| **Tier 4** (Non-Preferred Brand) | $95 copay | $190 copay | $285 copay |
| **Tier 5** (Specialty Tier) | 33% of the cost | Not Offered | Not Offered |

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

Group Health Cooperative (HMO) has a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at network pharmacies. To find a network pharmacy, you can look in your Provider and Pharmacy Directory, visit our website (medicare.ghc.org), or call Customer Service. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Coverage under these special situations is limited to a 30-day supply of medication.

## Group Health Cooperative Vital, Essential, and Optimal (HMO)

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

5% of the cost, or

$2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

## Section II – Summary of Benefits

| Benefit | Basic |
|---|---|
| **Optional Benefits** (you must pay an extra premium each month for these benefits) | |
| **Package 1: Dental HMO** | Benefits include:<br>• Preventive Dental<br>• Comprehensive Dental |
| **How much is the monthly premium?** | Additional $51.00 per month. You must keep paying your Medicare Part B premium and your $50 monthly plan premium. |
| **How much is the deductible?** | $100 per year. |
| **Is there any limit on how much I will pay for my covered services?** | Our plan pays up to $1,500 every year. |

## Additional Information About Group Health Cooperative (HMO)

| | |
|---|---|
| **Additional counseling to stop smoking and tobacco use** | Individual telephone-based tobacco cessation program includes up to 5 counseling calls from Quit For Life Program staff, dedicated support line, guides, and an individual plan. You can enroll multiple times during the year. |
| **Fitness Program** | You pay nothing for the SilverSneakers Fitness Program. |
| **Nursing Hotline** | You pay nothing for Group Health's consulting nurse line. |

| Vital | Essential | Optimal |
|---|---|---|
| Benefits include:<br>• Preventive Dental<br>• Comprehensive Dental | Benefits include:<br>• Preventive Dental<br>• Comprehensive Dental | Benefits include:<br>• Preventive Dental<br>• Comprehensive Dental |
| Additional $51.00 per month. You must keep paying your Medicare Part B premium and your $27 monthly plan premium. | Additional $51.00 per month. You must keep paying your Medicare Part B premium and your $113 monthly plan premium. | Additional $51.00 per month. You must keep paying your Medicare Part B premium and your $253 monthly plan premium. |
| $100 per year. | $100 per year. | $100 per year. |
| Our plan pays up to $1,500 every year. | Our plan pays up to $1,500 every year. | Our plan pays up to $1,500 every year. |
| Individual telephone-based tobacco cessation program includes up to 5 counseling calls from Quit For Life Program staff, dedicated support line, guides, and an individual plan. You can enroll multiple times during the year. | Individual telephone-based tobacco cessation program includes up to 5 counseling calls from Quit For Life Program staff, dedicated support line, guides, and an individual plan. You can enroll multiple times during the year. | Individual telephone-based tobacco cessation program includes up to 5 counseling calls from Quit For Life Program staff, dedicated support line, guides, and an individual plan. You can enroll multiple times during the year. |
| You pay nothing for the SilverSneakers Fitness Program. | You pay nothing for the SilverSneakers Fitness Program. | You pay nothing for the SilverSneakers Fitness Program. |
| You pay nothing for Group Health's consulting nurse line. | You pay nothing for Group Health's consulting nurse line. | You pay nothing for Group Health's consulting nurse line. |

**Multi-language Interpreter Services**

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-901-4600. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-901-4600. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-888-901-4600。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-888-901-4600。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-901-4600. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-901-4600. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-901-4600 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie 1-888-901-4600. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-888-901-4600 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-901-4600. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:**
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-901-4600. سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध ह. एक दुभाषिया प्राप्त करने के लिए, बस हम 1-888-901-4600 पर फोन कर. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-901-4600. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Português:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-901-4600. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-901-4600. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-901-4600. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-901-4600 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

**Customer Service**

**Toll-free 1-888-901-4600**

**TTY WA Relay:**
**Toll-free 1-800-833-6388 or 711**

Monday–Friday, 8 a.m.–8 p.m.

Extended hours
October 1–February 14,
8 a.m.–8 p.m., 7 days a week

**medicare.ghc.org**

GroupHealth®