2017 GroupHealth Medicare Advantage Plan Information

Thank you for your interest in applying for the GroupHealth Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from GroupHealth within 7 days of the application receipt.

Enrollment Packet – click links below to view the information
Star Rating Online Application Download Application: Puget / North / Spokane Online Premium Payment System Summary of Benefits: Puget / North / Spokane Provider Search Formulary Multi-language Support

Initial Enrollment Period (IEP)
If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.
Annual Enrollment Period (AEP)
Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.
Special Enrollment Period (SEP)
There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC PO Box 26540 Eugene, Oregon 97402	Fax: 1.541.284.2994 or 888.632.5470 Secure File Upload: Click here Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613.
Our website: http://hiwa.us/

GROUP HEALTH COOPERATIVE MEDICARE ADVANTAGE HMO

Summary of Benefits

BENEFITS EFFECTIVE:
JANUARY 1, 2017–DECEMBER 31, 2017

Medicare Advantage Plans with Part D prescription drugs

Group Health Medicare Advantage Vital (HMO)

Group Health Medicare Advantage Essential (HMO)

Group Health Medicare Advantage Optimal (HMO)

Medicare Advantage Plan with no Part D prescription drugs

Group Health Medicare Advantage Basic (HMO)

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

Y0033_H5050_MA0001585-04-16 Accepted 08-29-2016

This booklet gives you a summary of drug and health services we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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
- Prescription drug benefits
- Optional benefits (you must pay an extra premium for these benefits)

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

This document may be available in a non-English language.

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 **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 **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**.

Contact Group Health

Group Health Cooperative (HMO) phone numbers and website

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

Days and hours of operation

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

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

Things to know about Group Health Cooperative (HMO)

What do we cover?
Like all Medicare health plans, we cover everything that Original Medicare covers—and more. Some of the extra benefits are outlined in this booklet.

How do Group Health plans cover 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 other drugs administered by your provider.

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

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.

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.

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.

Generally, you must use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website, **medicare.ghc.org/providers**. Or call us and we will send you a copy of the provider and pharmacy directories.

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.

Service areas:

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

Monthly premium, deductible, and limits on how much you pay for covered services

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Monthly plan premium	**$28** per month In addition, you must keep paying your Medicare Part B premium, which is generally $104.90 per month.*	**$129** per month In addition, you must keep paying your Medicare Part B premium, which is generally $104.90 per month.*	**$270** per month In addition, you must keep paying your Medicare Part B premium, which is generally $104.90 per month.*	**$99** per month In addition, you must keep paying your Medicare Part B premium, which is generally $104.90 per month.*
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum out-of-pocket responsibility Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. If you reach the out-of-pocket maximum, you'll be covered at no cost for the rest of the year.	Your yearly limit(s) in this plan: **$5,900** for services you receive from in-network providers. Please note that you will still need to pay your monthly premiums and cost shares for your Part D prescription drugs.	Your yearly limit(s) in this plan: **$4,500** for services you receive from in-network providers. Please note that you will still need to pay your monthly premiums and cost shares for your Part D prescription drugs.	Your yearly limit(s) in this plan: **$2,000** for services you receive from in-network providers. Please note that you will still need to pay your monthly premiums and cost shares for your Part D prescription drugs.	Your yearly limit(s) in this plan: **$2,000** for services you receive from in-network providers. Please note that you will still need to pay your monthly premiums.
Inpatient hospital care[1,2] Our plan covers an unlimited number of inpatient days for a hospital stay	**$300** copay per day for days 1 through 6 You pay **nothing** per day for days 7 and beyond	**$250** copay per day for days 1 through 4 You pay **nothing** per day for days 5 and beyond	**$125** copay per day for days 1 through 2 You pay **nothing** per day for days 3 and beyond	**$250** copay per day for days 1 through 4 You pay **nothing** per day for days 5 and beyond
Doctor's office visits[1,2]	Primary care physician visit: **$10** copay Specialist visit: **$40** copay	Primary care physician visit: **$10** copay Specialist visit: **$35** copay	Primary care physician visit: **$10** copay Specialist visit: **$20** copay	Primary care physician visit: **$10** copay Specialist visit: **$30** copay

[1] May require prior authorization.
[2] May require a referral from your doctor.

*This is the 2016 Part B premium amount. Most people pay this standard premium amount for part B. This amount may change in 2017. We will provide updated rates as soon as Medicare releases them.

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

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Preventive care[1,2] All our plans provide the same benefits for preventive care.	You pay **nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography (LDCT) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay **nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography (LDCT) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay **nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography (LDCT) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay **nothing** Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Screening for lung cancer with low dose computed tomography (LDCT) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

[1] May require prior authorization.

[2] May require a referral from your doctor.

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Emergency care If you are admitted to the inpatient setting of the hospital within 1 day for the same condition, your emergency room copay is waived. See the "Inpatient hospital care" section of this booklet for other costs. Members are covered worldwide for urgent/emergent and post-stabilization care.	**$75** copay	**$75** copay	**$75** copay	**$75** copay
Urgently needed services Members are covered worldwide for urgent/emergent and post-stabilization care.	**$25** copay	**$25** copay	**$25** copay	**$25** copay
Diagnostic tests, lab and radiology services, and X-rays[1,2]	Diagnostic radiology services (such as MRIs, CT scans): **$250** copay Diagnostic tests and procedures: **$20** copay Lab services: **$10** copay Outpatient X-rays: **$20** copay Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost	Diagnostic radiology services (such as MRIs, CT scans): **$200** copay Diagnostic tests and procedures: You pay **nothing** Lab services: You pay **nothing** Outpatient X-rays: You pay **nothing** Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost	Diagnostic radiology services (such as MRIs, CT scans): **$50** copay Diagnostic tests and procedures: You pay **nothing** Lab services: You pay **nothing** Outpatient X-rays: You pay **nothing** 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 Diagnostic tests and procedures: You pay **nothing** Lab services: You pay **nothing** Outpatient X-rays: You pay **nothing** Therapeutic radiology services (such as radiation treatment for cancer): **20%** of the cost
Hearing services	Exam to diagnose and treat hearing and balance issues: **$10–40** copay, depending on the type of provider Routine hearing exam (for up to 1 every year): **$10–40** copay, depending on the type of provider	Exam to diagnose and treat hearing and balance issues: **$10–35** copay, depending on the type of provider Routine hearing exam (for up to 1 every year): **$10–35** copay, depending on the type of provider	Exam to diagnose and treat hearing and balance issues: **$10–20** copay, depending on the type of provider Routine hearing exam (for up to 1 every year): **$10–20** copay, depending on the type of provider Our plan pays up to $500 every year for hearing aids. You pay **nothing** for fitting. The allowance is a combined amount for both ears.	Exam to diagnose and treat hearing and balance issues: **$10–30** copay, depending on the type of provider Routine hearing exam (for up to 1 every year): **$10–30** copay, depending on the type of provider

[1] May require prior authorization.
[2] May require a referral from your doctor.

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Medicare-covered dental services[1,2] This category describes your coverage for Medicare-covered dental services. Optional supplemental dental coverage is on page 36.	**$40** 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** Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	**$30** copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)
Vision services[2] Limited to 1 routine eye exam per year. Diagnostic and treatment exams: unlimited visits	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$10–40** copay, depending on the type of provider Routine eye exam (for up to 1 every year): **$10–40** copay, depending on the type of provider Eyeglasses or contact lenses after cataract surgery: **$0 copay**, up to the Medicare allowable coverage amount	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$10–35** copay, depending on the type of provider Routine eye exam (for up to 1 every year): **$10–35** copay, depending on the type of provider Eyeglasses or contact lenses after cataract surgery: **$0 copay**, up to the Medicare allowable coverage amount Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses)	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$10–20** copay, depending on the type of provider Routine eye exam (for up to 1 every year): **$10–20** copay, depending on the type of provider Eyeglasses or contact lenses after cataract surgery: **$0 copay**, up to the Medicare allowable coverage amount Our plan pays up to $150 every year for contact lenses and eyeglasses (frames and lenses)	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **$10–30** copay, depending on the type of provider Routine eye exam (for up to 1 every year): **$10–30** copay, depending on the type of provider Eyeglasses or contact lenses after cataract surgery: **$0 copay**, up to the Medicare allowable coverage amount
Mental health care[1,2] For additional information, please refer to your Evidence of Coverage. Our plans cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	• Inpatient: **$300** copay per day for days 1 through 5 You pay **nothing** per day for days 6 and beyond • Outpatient for mental health and substance abuse therapy: Group visit: **$30** copay Individual visit: **$40** copay	• Inpatient: **$250** copay per day for days 1 through 4 You pay **nothing** per day for days 5 and beyond • Outpatient for mental health and substance abuse therapy: Group visit: **$25** copay Individual visit: **$35** copay	• Inpatient: **$125** copay per day for days 1 through 2 You pay **nothing** per day for days 3 and beyond • Outpatient for mental health and substance abuse therapy: Group visit: **$10** copay Individual visit: **$20** copay	• Inpatient: **$250** copay per day for days 1 through 4 You pay **nothing** per day for days 5 and beyond • Outpatient for mental health and substance abuse therapy: Group visit: **$25** copay Individual visit: **$30** copay
Skilled nursing facility (SNF)[1,2] Our plan covers up to 100 days in a SNF.	• You pay **nothing** per day for days 1 through 20 • **$160** copay per day for days 21 through 100	• You pay **nothing** per day for days 1 through 20 • **$100** copay per day for days 21 through 100	• You pay **nothing** per day for days 1 through 20 • **$25** copay per day for days 21 through 100	• **$20** copay per day for days 1 through 20 • **$50** copay per day for days 21 through 100

[1] May require prior authorization.
[2] May require a referral from your doctor.

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Outpatient rehabilitation[1,2]	Occupational, physical, speech, and language therapy visits: **$40** copay Cardiac rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for up to 36 weeks): **$40** copay Pulmonary rehab (limited to 36 sessions, no more than 2 sessions per day): **$30** copay	Occupational, physical, speech, and language therapy visits: **$35** copay Cardiac rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for up to 36 weeks): **$35** copay Pulmonary rehab (limited to 36 sessions, no more than 2 sessions per day): **$30** copay	Occupational, physical, speech, and language therapy visits: **$10** copay Cardiac rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for up to 36 weeks): **$10** copay Pulmonary rehab (limited to 36 sessions, no more than 2 sessions per day): **$10** copay	Occupational, physical, speech, and language therapy visits: **$30** copay Cardiac rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions for up to 36 weeks): **$30** copay Pulmonary rehab (limited to 36 sessions, no more than 2 sessions per day): **$30** copay
Ambulance[1] Hospital-to-hospital ambulance transfers initiated by Group Health are covered in full.	**$250** copay Emergency transfers are covered in full after **$250** copay.	**$150** copay Emergency transfers are covered in full after **$150** copay.	**$100** copay Emergency transfers are covered in full after **$100** copay.	**$150** copay Emergency transfers are covered in full after **$150** copay.
Transportation	You pay **nothing** Our plan covers up to **4** one-way trips for health-related purposes only.	You pay **nothing** Our plan covers up to **8** one-way trips for health-related purposes only.	You pay **nothing** Our plan covers up to **12** one-way trips for health-related purposes only.	You pay **nothing** Our plan covers up to **4** one-way trips for health-related purposes only.
Foot care (podiatry services)[1,2] Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**$40** copay	**$35** copay	**$20** copay	**$30** copay
Durable medical equipment and supplies[1] (wheelchairs, oxygen, braces, artificial limbs, etc.) If you go to a preferred vendor, your cost may be less.	**20%** of the cost	**20%** of the cost	**20%** of the cost	**20%** of the cost
Fitness program	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 the SilverSneakers® Fitness Program.
Medicare Part B drugs[1] Medicare Part B (medical insurance) doesn't cover most prescription drugs you self-administer at home, but does cover a limited number of drugs that are administered at a doctor's office or hospital. These include most injectable and infused drugs, and orally-administered cancer and anti-nausea medications.	**20%** of the cost	**20%** of the cost	**20%** of the cost	**20%** of the cost

[1] May require prior authorization.
[2] May require a referral from your doctor.

Vital, Essential, and Optimal Part D prescription drug coverage

1

Deductible stage
Because our Vital, Essential, and Optimal Part D plans do not have a deductible, your coverage starts immediately at the initial coverage stage, described below.

2

Initial coverage stage
The standard retail and mail order cost shares are listed below. You may get your drugs at network retail pharmacies and mail order pharmacies.

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$4 copay	$8 copay	$12 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 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

3

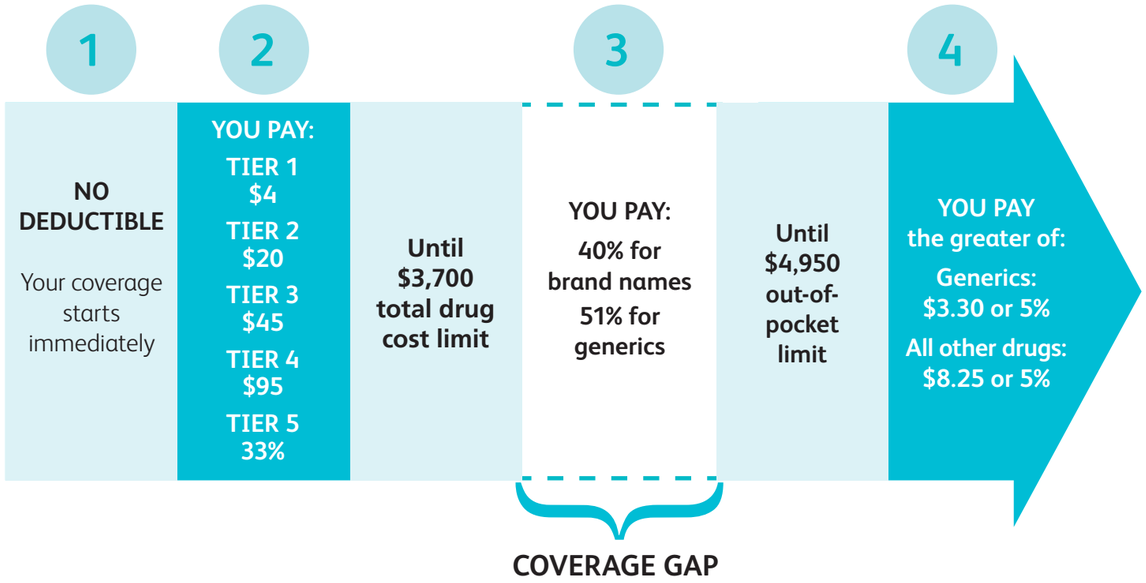
Coverage gap
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,700**.

After you enter the coverage gap, you pay **40%** of the plan's cost for covered brand name drugs and **51%** of the plan's cost for covered generic drugs until your costs total **$4,950**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

4

Catastrophic coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$4,950**, you pay the greater of:
5% of the cost, or **$3.30** copay for generic (including brand drugs treated as generic) and a **$8.25** copayment for all other drugs.

Here's a visual description of our Vital, Essential, and Optimal plans' Part D coverage.



NOTE: 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.

Additional benefits

Benefit	VITAL Cost share and details	ESSENTIAL Cost share and details	OPTIMAL Cost share and details	BASIC (No Part D) Cost share and details
Outpatient facility[1,2] Ambulatory surgical center and outpatient hospital	**$250** copay	**$200** copay	**$100** copay	**$200** copay
Renal dialysis[2]	**20%** of the cost	**20%** of the cost	**20%** of the cost	**20%** of the cost
Diabetes management[1,2]	Services—Diabetes self-management training: You pay **nothing** Supplies—Monitoring supplies and therapeutic shoes/inserts: **20%** of the cost	Services—Diabetes self-management training: You pay **nothing** Supplies—Monitoring supplies and therapeutic shoes/inserts: **20%** of the cost	Services—Diabetes self-management training: You pay **nothing** Supplies—Monitoring supplies and therapeutic shoes/inserts: **20%** of the cost	Services—Diabetes self-management training: You pay **nothing** Supplies—Monitoring supplies and therapeutic shoes/inserts: **20%** of the cost
Home health care[1,2]	You pay **nothing**	You pay **nothing**	You pay **nothing**	You pay **nothing**
Hospice You must use a Medicare-certified hospice.	You pay **nothing** You may have to pay part of the costs for drugs and respite care.	You pay **nothing** You may have to pay part of the costs for drugs and respite care.	You pay **nothing** You may have to pay part of the costs for drugs and respite care.	You pay **nothing** You may have to pay part of the costs for drugs and respite care.
Chiropractic care (Spinal manipulation only)	**$20** copay	**$20** copay	**$10** copay	**$20** copay
Alternative care	Acupuncture: **not covered** Naturopathy: **not covered** Non-spinal chiropractic care: **not covered**	Acupuncture: **not covered** Naturopathy: **not covered** Non-spinal chiropractic care: **not covered**	Acupuncture: **$10** copay Naturopathy: **$10** copay Non-spinal chiropractic care: **$10** copay Coverage for any combination of **12 visits** per year for acupuncture, naturopathic medicine, and/or chiropractic manipulation *for other than the spine*. Members must see plan contracted providers.	Acupuncture: **not covered** Naturopathy: **not covered** Non-spinal chiropractic care: **not covered**
Consulting nurse helpline Group Health's Consulting Nurse Service	You pay **nothing**	You pay **nothing**	You pay **nothing**	You pay **nothing**
Quit for Life Program Additional counseling to stop smoking and tobacco use	You pay **nothing**	You pay **nothing**	You pay **nothing**	You pay **nothing**

[1] May require prior authorization.
[2] May require a referral from your doctor.

Optional dental benefits (you must pay an extra premium each month for these benefits)

Oral health is an important part of your overall health. Group Health Cooperative has partnered with Delta Dental of Washington to offer you the Delta Dental Premier Plan as part of your complete Group Health Medicare Advantage HMO plan when you choose optional dental benefits.

This plan doesn't have an out-of-network benefit but lets you choose from a large network of dentists. It's designed to provide you with full coverage for your semiannual dental checkups so that dental health problems can be detected early.

COST SHARES	PLAN #01000
Monthly premium	**$54** per member
Deductible	**$100** per person (waived on preventive and diagnostic care)
Annual benefit maximum	$1,500 per member
BENEFIT	
Preventive and diagnostic care • Routine exams and cleanings (two per calendar year) • Fluoride treatment (two per calendar year) • Periodontal cleanings • Dental X-rays	Covered at 100% You pay **$0**
Basic dental expenses • Fillings/stainless steel crowns • Oral surgery • Endodontics (i.e., root canal treatment) • Periodontics	Covered at 80% You pay **20%**
Major expenses • Crowns, implants, and onlays • Dentures, bridges, and partials • Denture adjustments and relines	Covered at 50% You pay **50%**

If you have any questions, please call Delta Dental Customer Service **1-877-719-4006** (TTY WA Relay **1-800-833-6388)**, Monday–Friday, 8 a.m.–5 p.m., or visit **DeltaDentalWA.com**.

Group Health Nondiscrimination Notice and Language Access Services

GroupHealth®

GROUP HEALTH NONDISCRIMINATION NOTICE

Group Health Cooperative and Group Health Options, Inc. ("Group Health") comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact the Group Health Civil Rights Coordinator.

If you believe that Group Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Group Health Civil Rights Coordinator, Group Health Headquarters, 320 Westlake Ave. N., Suite 100, GHQ-E2N, Seattle, WA 98109, 206-448-5819, 206-877-0645 (Fax), complianceoffice@ghc.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Group Health Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ACCESS SERVICES

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-901-4636 (TTY: 1-800-833-6388 or 711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

中文 **(Chinese)**：注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-901-4636 (TTY：1-800-833-6388 / 711）。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-901-4636 (TTY：1-800-833-6388 / 711）.

한국어**(Korean):** 주의： 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

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Filipino (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-901-4636 (телетайп: 1-800-833-6388 / 711).

ភាសាខ្មែរ (Khmer)៖ **ប្រយ័ត្ន៖** ប្រើសិនអ្នកនិយាយខែរ, សេជំនួយែជក យេមិនគិតល គឺចនសំប់បំរអេក។ ចូរទូ រស័ព1-888-901-4636 (TTY: 1-800-833-6388 / 711។

日本語(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-901-4636（TTY:1-800-833-6388 / 711）まで、お電話にてご連絡ください。

አማርኛ (Amharic)፥ ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-901-4636 (መስማት ለተሳናቸው: 1-800-833-6388 / 711).

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

العربية (Arabic): لديكم حق الحصول على مساعدة ومعلومات في ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-901-4636 (رقم هاتف الصم والبكم: 1-800-833-6388 / 711).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-901-4636 (TTY: 1-800-833-6388 / 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-901-4636 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-833-6388 / 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-901-4636 (ATS : 1-800-833-6388 / 711).

Română (Romanian): ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

Adamawa (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-901-4636 (TTY: 1-800-833-6388 / 711).

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس 1-888-901-4636 (TTY: 1-800-833-6388 / 711) بگیرید.

GroupHealth®

CONTACT US

1-800-446-8882
TTY WA Relay:
1-800-833-6388 or 711

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

medicare.ghc.org

Group Health Cooperative is an HMO plan with a Medicare contract. Enrollment in Group Health HMO depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Other Pharmacies and Providers are available in our network. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.