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Group Health Options, Inc.
Medicare Supplement Plans—2017

The Group Health difference

Why choose Group Health?

Here are just a few of the reasons why many Medicare enrollees choose—and re-enroll in—our plans.

Access to the providers you want to see

Group Health's Medicare Supplement plans provide access to any physician, specialist, and hospital that accepts Medicare, with no referral needed. **(However, Medicare Supplement members cannot receive care at Group Health Medical Centers.)** Group Health also supports good health in the many communities we serve through our medical education and a nationally recognized research institute.

Free prescription drug discount program

Our OptumRx Prescription Drug Discount Program is offered on all of our Medicare Supplement plans at no additional cost or obligation to you. The program is not a Part D prescription drug plan and may be discontinued at any time.

GlobalFit® health and fitness program

Group Health offers all members and their dependents the GlobalFit health and fitness discount program. The program includes access to a network of health clubs, as well as exercise videos and equipment you can use at home. A nutrition program is also available. Visit GlobalFit or call 800-294-1500 for more information.

GlobalFit is not part of your Medicare Supplement plan and may be discontinued at any time.

Convenient online tools

MyGroupHealth for Members at ghc.org makes managing your health care easy, 24/7. Just log on to ghc.org via your computer or smartphone and you can:

- Pay premiums
- Check your claims status
- Review the details of your health coverage
- Access explanation-of-benefits statements for recent care
- Find reliable information on thousands of health topics

Understanding Medicare

Whether you are turning 65 and are new to Medicare, are looking to change Medicare plans, or are researching Medicare for your parents, you probably have a lot of questions. The information below will give you a brief overview of Original Medicare (Parts A and B), Part D prescription drug coverage, and Medicare Supplement plans. For a more extensive explanation of your Medicare coverage options, visit www.ssa.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

What Medicare Supplement isn't

These plans supplement Original Medicare only. They are not the same as Medicare Advantage plans, Medicaid, employer or union plans, TRICARE, VA benefits, long-term care insurance policies, or Indian Health service, Tribal, or Urban plans. They do not include prescription drug coverage. Individuals may enroll in a stand-alone Medicare prescription drug plan (Part D) for this coverage.

Part A Inpatient hospital insurance

- Usually $0 premium if you or your spouse worked over 10 years or 40 quarters
- Inpatient care in hospitals such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals
- Skilled nursing facilities (not custodial or long-term care)
- Hospice care
- Home health care services

Part B Medical insurance

- $109, however, those with higher incomes may pay a higher premium*
- Doctor services
- Outpatient care
- Some other services not covered by Part A

Does NOT cover:

Long-term care, dental care, eye care, hearing aids, cosmetic surgery, alternative health care

Part D Prescription drug coverage

Before selecting a Medicare Part D plan, you should determine if the prescription drugs you currently take are on the plan's formulary, and what the costs are. Plans might differ in drugs covered, although all Part D plans will cover the drugs that are mandated by Medicare (limitations and preauthorizations may apply). Delaying enrollment in a qualified Part D plan may result in a late enrollment penalty (LEP).

Medigap Medicare Supplement plans

There are 12 standardized Medicare Supplement (also called MediGap) plans (A–N) and each plan has different benefits. They help "fill the gap" and pay coinsurance, copayments, and/or deductibles for benefits that Original Medicare deems medically necessary, as well as other services not covered by Medicare.

If you have questions about any of our Medicare Supplement plans or about the application process, please feel free to contact us at **1-800-628-3753**. Our knowledgeable staff will be happy to answer your questions and guide you through the application process. Or visit us online at **ghc.org/medsupp**.

*The 2017 monthly premium is $134 for about 30% of Medicare beneficiaries, such as those receiving the Part B benefit for the first time in 2017.

Summary of benefits	What you pay on Original Medicare	Plan A (2010 standardized) You pay	Plan F (2010 standardized) You pay	Plan K You pay	Plan N You pay
Monthly premium	**Part A**: Usually $0 **Part B:** $109 *	**$135**	**$251**	**$87**	**$141**
Deductible(s)	Part A deductible: $1,316/benefit period Part B deductible: $183/calendar year	Part A deductible: $1,316/benefit period Part B deductible: $183/calendar year	$0 $0	50% of Part A deductible: $658/benefit period Part B deductible: $183/calendar year	$0 Part B deductible: $183/calendar year
Doctor and hospital choice	You may go to any doctor, specialist, or hospital that accepts Medicare	You may go to any doctor, specialist, or hospital that accepts Medicare	You may go to any doctor, specialist, or hospital that accepts Medicare	You may go to any doctor, specialist, or hospital that accepts Medicare	You may go to any doctor, specialist, or hospital that accepts Medicare
Preventive services	No copay or coinsurance	$0	$0	$0	$0
Outpatient doctor office visits	Part B deductible: $183; 20% coinsurance	Part B deductible: $183; $0	$0	Part B deductible: $183; 10% coinsurance	$20 copay
Diagnostic tests, X-rays, lab and radiology services *Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.*	**Diagnostic tests and X-rays:** Part B deductible: $183; 20% coinsurance **Lab services:** $0 copay; must be medically necessary for diagnosis/treatment	**Diagnostic tests and X-rays:** Part B deductible: $183; $0 **Lab services:** $0 copay; must be medically necessary for diagnosis/treatment	**Diagnostic tests and X-rays:** $0 **Lab services:** $0 copay; Must be medically necessary for diagnosis/treatment	**Diagnostic tests and X-rays:** Part B deductible: $183; 10% coinsurance **Lab services:** $0 copay; must be medically necessary for diagnosis/treatment	**Diagnostic tests and X-rays:** Part B deductible: $183; $0 **Lab services:** $0 copay; must be medically necessary for diagnosis/treatment
Outpatient surgery	Part B deductible: $183; 20% coinsurance	Part B deductible: $183; $0	$0	Part B deductible: $183; 10% coinsurance	Part B deductible: $183; $0
Ambulance	Part B deductible: $183; 20% coinsurance	Part B deductible: $183; $0	$0	Part B deductible: $183; 10% coinsurance	Part B deductible: $183; $0
Emergency room	**Physician's services:** Part B deductible: $183; 20% coinsurance **Facility services:** Specified copayment. Copay cannot exceed Part A deductible for each service provided by the hospital. Copay waived if admitted within 3 days of ER visit.	**Physician's services:** Part B deductible: $183; $0 **Facility services:** Specified copayment. Copay cannot exceed Part A deductible for each service provided by the hospital. Copay waived if admitted within 3 days of ER visit.	**Physician's services:** $0 **Facility services:** $0	**Physician's services:** Part B deductible: $183; 10% coinsurance **Facility services:** Specified copayment. Copay cannot exceed Part A deductible for each service provided by the hospital. Copay waived if admitted within 3 days of ER visit.	**Physician's services:** Part B deductible: $183; $20 copay **Facility services:** $50 copay
Inpatient hospital care *Includes 60 lifetime reserve days*	Part A deductible: $1,316 Days 61-90: $329/day; days 91-150: $658/day; additional 365 days 100%	Part A deductible: $1,316 Days 61-90: $0; days 91-150: $0; additional 365 days: $0	$0 Days 61-90: $0; days 91-150: $0; additional 365 days: $0	50% of Part A deductible: $658 Days 61-90: $0; days 91-150: $0; additional 365 days: $0	$0 Days 61-90: $0; days 91-150: $0; additional 365 days: $0
Skilled nursing facility *Subject to prior 3-day inpatient admit*	Days 1-20: $0; days 21-100: $164.50/day; days 101+: 100%	Days 1-20: $0; days 21-100: $164.50/day; days 101+: 100%	Days 1-20: $0; days 21-100: $0; days 101+: 100%	Days 1-20: $0; days 21-100: $82.25/day; days 101+: 100%	Days 1-20: $0; days 21-100: $0; days 101+: 100%
Home health care	No copay or coinsurance	$0	$0	$0	$0
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	$0	$0	You pay 50% of the patient part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	$0
Durable medical equipment	Part B deductible: $183; 20% coinsurance	Part B deductible: $183; $0	$0	Part B deductible: $183; 10% coinsurance	$0
Vision services	**Vision exam:** 20% coinsurance **Vision hardware:** $0 for one pair of eyeglasses or contact lenses after cataract surgery. *Supplemental routine eye exams and eyeglasses (lenses and frames) are not covered.*	**Vision exam:** $0 **Vision hardware:** $0 for one pair of eyeglasses or contact lenses after cataract surgery. *Supplemental routine eye exams and eyeglasses (lenses and frames) are not covered.*	**Vision exam:** $0 **Vision hardware:** $0 for one pair of eyeglasses or contact lenses after cataract surgery. *Supplemental routine eye exams and eyeglasses (lenses and frames) are not covered.*	**Vision Exam:** 10% coinsurance **Vision hardware:** $0 for one pair of eyeglasses or contact lenses after cataract surgery. *Supplemental routine eye exams and eyeglasses (lenses and frames) are not covered.*	**Vision exam:** $0 **Vision hardware:** $0 for one pair of eyeglasses or contact lenses after cataract surgery. *Supplemental routine eye exams and eyeglasses (lenses and frames) are not covered.*
Foreign travel, emergency	Not covered	Not covered	First $250; 20% coinsurance; $50,000 lifetime maximum	Not covered	First $250; 20% coinsurance; $50,000 lifetime maximum
Wellness/education services	Not covered	GlobalFit**	GlobalFit**	GlobalFit**	GlobalFit**

Should the subscriber elect to make monthly payments in advance of the current monthly rate due date and the revised rate is to become effective at the beginning of a month for which the subscriber has already paid, the next billing will include a retroactive adjustment for the revised rate. *Group Health can only raise your monthly premium if all Group Health contracts like yours are raised in the state.*

MEDICARE PART A—HOSPITAL SERVICES—PER BENEFIT PERIOD Benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. When your Part A hospital benefits are exhausted, Group Health will pay whatever Medicare would have paid for an additional 365 days. During this time the hospital cannot bill you for the difference between its billed charges and the amount Medicare would pay.

*The 2017 monthly premium is $134 for about 30% of Medicare beneficiaries, such as those receiving the Part B benefit for the first time in 2017. **GlobalFit is not part of your Medicare Supplement plan and may be discontinued at any time.

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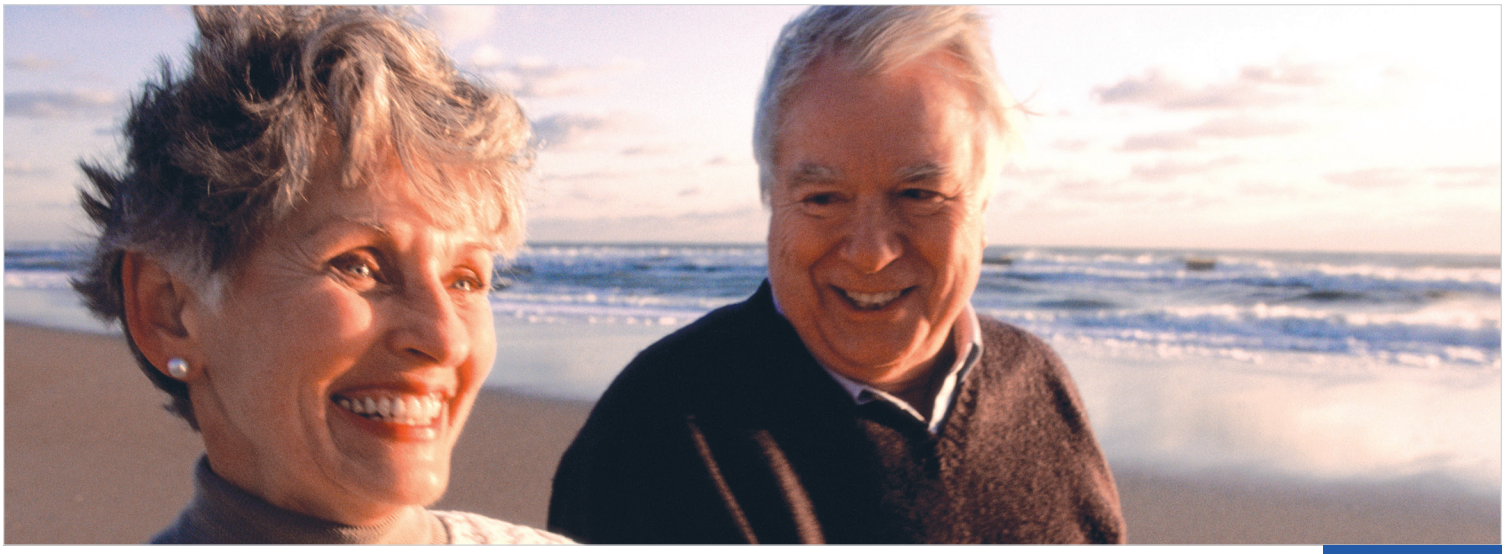

Eligibility

You are eligible to enroll in Group Health's Medicare Supplement Plan A (2010 Standardized), Plan F (2010 Standardized), Plan K, and Plan N if you are:

- Age 65, or turning age 65 in the next 3 months
- Enrolled in Medicare Part A and Part B
- A resident of the state of Washington

Initial enrollment period

During the first 6-month period from the date you initially enroll in Medicare Part B (at age 65 or older), you cannot be denied coverage on any Medicare Supplement plan, regardless of your health.

It's simple!

How to enroll:

- Mail us the appropriate forms (see enclosed checklist) in the enclosed prepaid envelope, or fax them to **206-877-0655**
- Contact your independent producer/broker/agent.

Glossary of terms

Here are some of the most common Medicare terms. Understanding these will help you choose the plan that's right for you.

Benefit period—The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. (Note: When Part A hospital benefits are exhausted, Group Health will pay whatever Medicare would have paid for an additional 365 days. During this time the hospital cannot bill you for the difference between its billed charges and the amount Medicare would pay.)

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, or hospital outpatient visit. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Lifetime reserve days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medically necessary—Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of medicine.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts Medicare recipients can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Premium—The monthly fee you pay to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive care services—Health care to prevent or detect illness at an early stage, when treatment is likely to work best. Examples of preventive services include Pap tests, flu shots, and screening mammograms.

Skilled nursing facility (SNF) care—Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

For a more comprehensive glossary, please visit medicare.gov.

Frequently asked questions

Can I buy a Group Health Options, Inc. Medicare Supplement plan if I am under age 65 or disabled?
Group Health does not offer Medicare Supplement plans for those under age 65, or for those on Medicare due to disability.

What happens if I become eligible for Medicaid, but already have a Medicare Supplement contract?
If you already have a Medicare Supplement plan and then become eligible for Medicaid, Group Health must suspend coverage and waive the monthly premiums during the time you are eligible for Medicaid, not to exceed a period of 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If your Medicaid benefits end, and you notify Group Health within 90 days of the date they end, we will reinstate an equivalent policy without a pre-existing condition waiting period.

Can Group Health increase my monthly premium as I get older?
No. We can only raise your monthly premium if we raise the monthly rate for all contracts like yours in the state of Washington. Premium increases require approval by the state Office of the Insurance Commissioner. Generally, we issue new premium rates every 12–18 months.

What if my employer offers a continuation or conversion from my employer group plan?
Many employers offer continuation or conversion as a "retirement benefit," allowing retirees to continue the group coverage or convert to a retiree health plan. Make sure you compare the benefits offered by a retirement plan to the standardized Medicare Supplement plans before making a decision. You may find that retirement plans offer more comprehensive benefits.

Can Group Health turn me down for a Medicare Supplement plan?
If you meet all of the eligibility requirements, are enrolled in Medicare Parts A and B, and are applying within six months of your initial enrollment in Part B, you will **not** be declined for Medicare Supplement coverage with Group Health. (If applying outside of your Initial Enrollment Period, a health statement may be required.)

Group Health Options, Inc.
Medicare Supplement Sales
320 Westlake Ave N Ste 100, Seattle, WA 98109-5233
For sales information, please call 1-800-628-3753
TTY 1-800-833-6388
For Customer Service, call 206-901-4636 or 1-888-901-4636

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