GlobalHealth

Annual Notice of Changes

January 1 – December 31, 2017

Generations Premier (HMO)

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.

1-844-280-5555 (TTY users call 711)
8 a.m. to 8 p.m., 7 days a week
(October 1 - February 14)
8 a.m. to 8 p.m., Monday - Friday
(February 15 - September 30)
www.GlobalHealth.com/medicare

H3706_OPT3TOPREMIEREOC_2017 File & Use 09/14/2016

Generations Premier (HMO) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2017

You are currently enrolled as a member of GlobalHealth Medicare Option 3 (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

Additional Resources

- Please contact our Customer Care number at (405) 280-5555 (local) or 1-844-280-5555 (toll-free) for additional information. (TTY users should call 711.) Hours are 8:00 a.m. to 8:00 p.m., seven days a week, from October 1 – February 14, and 8:00 a.m. to 8:00 p.m. Monday – Friday from February 15 – September 30.
- Customer Care has free language interpreter services available for non-English speakers (phone numbers are in Section 8.1 of this booklet).
- This information is also available in large print.
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About Generations Premier (HMO)

- GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.
- When this booklet says "we," "us," or "our," it means GlobalHealth, Inc. When it says "plan" or "our plan," it means Generations Premier (HMO).

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Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 2.1, 2.5, and 3 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Sections 2.3 and 2.4 for information about our *Provider & Pharmacy Directory*.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to stay with Generations Premier (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 4.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Generations Premier (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$90	$111.30
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$4,500	$4,500
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $30 per visit	Primary care visits: $0 per visit Specialist visits: $30 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $300 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 through 190.	• You pay a $275 copay per day for days 1 through 3 • There is no coinsurance, copayment, or deductible for days 4 through 90 • There is no coinsurance, copayment, or deductible for days 91 through 190

Cost	2016 (this year)	2017 (next year)
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $9 • Drug Tier 2: $17 • Drug Tier 3: $45 • Drug Tier 4: $95 • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $4 • Drug Tier 2: $12 • Drug Tier 3: $40 • Drug Tier 4: $90 • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $4 • Drug Tier 2: $12 • Drug Tier 3: $40 • Drug Tier 4: $90 • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share is not covered. Standard 90-day Retail Cost-Share:	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15

Cost	2016 (this year)	2017 (next year)
	• Drug Tier 1: $15 • Drug Tier 2: $35 • Drug Tier 3: $105 • Drug Tier 4: $275 Preferred 90-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $30 • Drug Tier 3: $100 • Drug Tier 4: $270 Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $30 • Drug Tier 3: $100 • Drug Tier 4: $270 Preferred 90-day Mail-order Cost-share not covered.	• Drug Tier 3: $42 • Drug Tier 4: 30% of the total cost • Drug Tier 5: 33% of the total cost. Standard 90-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost Preferred 90-day Retail Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $126 • Drug Tier 4: 40% of the total cost Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $94 • Drug Tier 4: 50% of the total cost Preferred 90-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $15 • Drug Tier 3: $84 • Drug Tier 4: 30% of the total cost

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Generations Premier (HMO) in 2017

On January 1, 2017, GlobalHealth, Inc. will be combining GlobalHealth Medicare Option 3 (HMO) with one of our plans, Generations Premier (HMO).

If you do nothing to change your Medicare coverage by December 7, 2016, we will automatically enroll you in our Generations Premier (HMO). This means starting January 1, 2017, you will be getting your medical and prescription drug coverage through Generations Premier (HMO). If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in GlobalHealth Medicare Option 3 (HMO) and the benefits you will have on January 1, 2017 as a member of Generations Premier (HMO).

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$90	$111.30

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,500	$4,500 Once you have paid $4,500 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

Our network has changed more than usual for 2017. An updated *Provider & Pharmacy Directory* is located on our website at www.globalhealth.com/medicare. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **We strongly suggest that you review our current *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

Our network has changed more than usual for 2017. An updated *Provider & Pharmacy Directory* is located on our website at www.globalhealth.com/medicare. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **We strongly suggest that you review our current *Provider & Pharmacy Directory* to see if your pharmacy is still in our network.**

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2017 Evidence of Coverage.*

Cost	2016 (this year)	2017 (next year)
Ambulance services	You pay a $50 copay for Medicare-covered ambulance services per trip. If you are admitted to the hospital, you do not have to pay for the ambulance services.	You pay a $50 copay for Medicare-covered ambulance services per one-way trip. If you are admitted to the hospital, you do not have to pay the ambulance services copay.

Cost	2016 (this year)	2017 (next year)
Colorectal cancer screening	For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy
Dental services	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • Medicare-covered dental services that are an integral part of a covered medical service and performed by either the hospital's staff dentist or a physician (this

Cost	2016 (this year)	2017 (next year)

	• Preventive dental services
	  o Cleaning (for up to 2 every year)
	  o Dental x-ray(s) (for up to 2 every year)
	  o Oral exam (for up to 2 every year)
	• Prosthodontics (Dentures)
	  o 1 visit per year
	
	Up to a maximum benefit of $500 per year.
	
	There is no coinsurance, copayment, or deductible for limited dental services.
	
	There is no coinsurance, copayment, or deductible for preventive dental services.
	
	You pay 50% of the total cost for dentures.
		does not include services in connection with care, treatment, filling, removal, or replacement of teeth)
		• Preventive dental services
		  o Cleaning (for up to 2 every year)
		  o Dental x-ray(s) (for up to 2 every year)
		  o Oral exam (for up to 2 every year)
		• Prosthodontics (Dentures)
		  o 1 set per year
		
		There is no coinsurance, copayment, or deductible for Medicare-covered dental services.
		
		There is no coinsurance, copayment, or deductible for preventive dental services.
		
		You pay 50% of the total cost of dentures.
		We will only pay up to a total of $500 for dentures per year. If the dentures you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance.
		
		Prior authorization is required for Medicare-covered dental services.

Cost	2016 (this year)	2017 (next year)
Diabetes self-management training, diabetic services and supplies	There is no coinsurance, copayment, or deductible for diabetic services and supplies and therapeutic shoes or inserts. There is no coinsurance, copayment, or deductible for diabetes self-management training. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes monitoring supplies or for Medicare-covered therapeutic shoes or inserts. There is no coinsurance, copayment, or deductible for diabetes self-management training. If other medical services are provided, for other medical conditions, in the same visit, then the appropriate physician cost-sharing applies for the additional services rendered during that office visit. Prior authorization is required.
Durable Medical Equipment (DME)	You pay 20% of the total cost for durable medical equipment. Prior authorization is required.	You pay 20% of the total cost for durable medical equipment. If your home health care agency provides the equipment, you do not have to pay the durable medical equipment coinsurance. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Emergency care	You pay a $50 copay for Medicare-covered emergency care services. If you are admitted to the hospital within 48 hours for the same condition, you do not have to pay your share of the cost for emergency care. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered.	You pay a $50 copay per visit for all Medicare-covered emergency care services received during visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay the emergency care copay. If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copay. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, we will try to arrange for network providers to take over care as soon as the medical condition and the circumstances allow. Otherwise, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

Cost	2016 (this year)	2017 (next year)
Hearing services	You pay a $20 copay for Medicare-covered diagnostic hearing exams to diagnose and treat hearing and balancing issues. You pay a $20 copay for up to one supplemental routine hearing exam every year. Must be performed by your PCP.	There is no coinsurance, copayment, or deductible for Medicare-covered PCP diagnostic hearing and balance evaluations. You pay a $20 copay per visit for specialist exams to diagnose and treat hearing and balance issues. You pay a $20 copay for one supplemental routine hearing exam. Prior authorization is required for specialist exams to diagnose and treat hearing and balancing issues.
Home health agency care	There is no coinsurance, copayment, or deductible for Medicare-covered home health visit. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered home health visits. Copayments and/or coinsurances will apply if additional benefits requiring cost-sharing are not provided by a home health agency. Prior authorization required at least two (2) business days prior to services being rendered for all home health care.

Cost	2016 (this year)	2017 (next year)
Inpatient hospital care	Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. For Medicare-covered hospital stays at an in-network hospital: • You pay a $300 copay per day for days 1-5. • You pay nothing per day for days 6-90. • You pay nothing per day for days 91-190. Hospital copays apply on the date of admission. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Prior authorization is required. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost-sharing you would pay at a network hospital.	Blood - including storage and administration. All components of blood are covered beginning with the first pint used. For Medicare-covered hospital stays at an in-network hospital: • You pay a $275 copay per day for days 1 through 3. • There is no coinsurance, copayment, or deductible for days 4 through 90. • There is no coinsurance, copayment, or deductible for days 91 through 190. Hospital copays apply on the date of admission. Prior authorization is required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Cost	2016 (this year)	2017 (next year)
Inpatient mental health care	For Medicare-covered hospital stays in a network hospital: • You pay a $300 copay per day for days 1-5. • You pay nothing per day for days 6-90. • You pay nothing per day for days 91-190. Must be provided by an in-network provider arranged through MHNet.	For Medicare-covered hospital stays in a network hospital: • You pay a $325 copay per day for days 1 through 3. • There is no coinsurance, copayment, or deductible for days 4 through 90. • There is no coinsurance, copayment, or deductible for day s 91 through 190. Hospital copays apply on the date of admission. Prior authorization is required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Medicare Part B prescription drugs	You pay 20% of the total cost for Medicare Part B covered drugs. Prior authorization is required.	You pay 20% of the total cost for Medicare Part B covered drugs. Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have a 0% cost-sharing. All other Medicare Part B drugs will have a 20% cost-sharing. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Outpatient diagnostic tests and therapeutic services and supplies	Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. There is no coinsurance, copayment, or deductible for Medicare-covered: • Lab services • Diagnostic procedures and tests • Outpatient X-rays • Therapeutic radiology services You pay a $150 copay for Medicare-covered diagnostic radiology services (such as MRIs, CT scans). One copay per visit no matter how many specialty studies are performed. If studies are performed as part of an ER visit, then no copay applies. Prior authorization is required.	Blood - including storage and administration. All components of blood are covered beginning with the first pint used. There is no coinsurance, copayment, or deductible for Medicare-covered: • Lab services • Diagnostic procedures and tests • Outpatient X-rays You pay a $30 copay per visit for therapeutic radiology services. If these services are performed during a physician's office visit you do not have to pay the outpatient diagnostic tests and therapeutic services and supplies copays. You pay a $150 copay per visit for Medicare-covered diagnostic radiology services (such as MRIs, CT scans). There is no coinsurance, copayment, or deductible for Medicare-covered surgical supplies, devices used to reduce fractures and dislocations, or blood. Prior authorization is required for therapeutic radiology services and diagnostic radiology services (except for emergency care).

Cost	2016 (this year)	2017 (next year)
Outpatient hospital services	You pay a $200 copay for each Medicare-covered outpatient hospital facility visit. Prior authorization is required (except for emergency care).	You pay a $125 copay per visit for Medicare-covered services in a preferred outpatient facility. You pay a $250 copay per visit for Medicare-covered services in a non-preferred outpatient facility. The *Provider & Pharmacy Directory* will indicate preferred status. If you are admitted to the inpatient acute level of care from outpatient services, you do not have to pay the outpatient hospital services copay. See "Partial hospitalization services" for cost-sharing information. Prior authorization is required (except for emergency care).
Outpatient mental health care	You pay a $30 copay for each Medicare-covered individual therapy visit. You pay a $30 copay for each Medicare-covered group therapy visit. Must be provided by an in-network provider arranged through MHNet.	There is no coinsurance, copayment, or deductible for Medicare-covered individual therapy sessions. There is no coinsurance, copayment, or deductible for Medicare-covered group therapy sessions.

Cost	2016 (this year)	2017 (next year)
Outpatient rehabilitation services	You pay a $25 copay for each Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy visit. Prior authorization is required.	You pay a $25 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy. If these services are provided at your home, you pay the home health cost-sharing instead. Prior authorization required at least two (2) business days prior to services being rendered.
Outpatient substance abuse services	You pay a $30 copay for each Medicare-covered individual therapy visit. You pay a $30 copay for each Medicare-covered group therapy visit. Must be provided by an in-network provider arranged through MHNet.	There is no coinsurance, copayment, or deductible for Medicare-covered individual therapy sessions. There is no coinsurance, copayment, or deductible for Medicare-covered group therapy sessions.

Cost	2016 (this year)	2017 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $125 copay for each Medicare-covered ambulatory surgical center visit. You pay a $200 copay for each Medicare-covered outpatient hospital facility visit. Prior authorization is required.	You pay a $125 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $125 copay per visit for Medicare-covered services in a preferred outpatient facility. You pay a $250 copay per visit for Medicare-covered services in a non-preferred outpatient facility. The *Provider & Pharmacy Directory* will indicate preferred status. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery, you do not have to pay the outpatient surgery or ambulatory surgery copay. Prior authorization is required.
Partial hospitalization services	You pay nothing for Medicare-covered partial hospitalization program services. Must be provided by an in-network provider arranged through MHNet.	You pay a $30 copay per day for Medicare-covered partial hospitalization program services. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Physician/ Practitioner services, including doctor's office visits	You pay nothing for each Medicare-covered primary care physician visit. You pay a $30 copay for each Medicare-covered specialist visit. Prior authorization is required for specialist visits.	There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services. You pay a $30 copay per office visit for Medicare-covered specialist services. You pay the regular office visit copay to see a physician assistant, nurse practitioner, or other provider. See "Dental services" for non-routine dental care cost-sharing information. Prior authorization is required for specialist visits except OB/GYN office visits.

Cost	2016 (this year)	2017 (next year)
Screening for lung cancer with low dose computed tomography (LDCT)	Screening for lung cancer with low dose computed tomography (LDCT) is not covered.	For qualified individuals, a LDCT is covered every 12 months. Eligible enrollees are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Cost	2016 (this year)	2017 (next year)
Services to treat kidney disease and conditions	You pay 20% of the total cost for Medicare-covered renal dialysis. You pay nothing for Medicare-covered kidney disease education services. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services including self-dialysis training. You pay 20% of the total cost for Medicare-covered renal dialysis. You pay the home health agency care cost share for home dialysis equipment if provided by a home health agency. Otherwise, you pay the durable medical equipment cost share. You pay the home health agency care cost share for home support services. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Skilled nursing facility (SNF) care	A three (3) day prior qualifying inpatient hospital stay is required. Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. For Medicare-covered skilled nursing facility stays: • You pay nothing per day for days 1 through 20. • You pay a $50 copay per day for days 21 through 100. Prior authorization and 3-day hospital qualifying stay is required.	Prior hospital stay is <u>not</u> required. Blood - including storage and administration. All components of blood are covered beginning with the first pint used. For Medicare-covered skilled nursing facility stays: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a $50 copay per day for days 21 through 100. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Vision care	You pay a $45 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. You pay nothing for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. You pay a $45 copay for one supplemental routine eye exam per year. You pay nothing for one pair of eyeglasses per year. There is a $200 coverage limit for eye wear per year (frames and lenses).	You pay a $45 copay per visit for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including glaucoma screening. You pay a $45 copay for one supplemental routine eye exam per year. There is no coinsurance, copayment, or deductible for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. There is no coinsurance, copayment, or deductible for one supplemental pair of eyeglasses (frames and lenses) per year. We will only pay up to a total of $200 for all eye wear per year. If the eye wear you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. Prior authorization is required for glaucoma screening.

Cost	2016 (this year)	2017 (next year)
Wigs for Hair Loss Related to Chemotherapy	There is no coinsurance, copayment or deductible for wigs for hair loss related to chemotherapy. Our plan provides reimbursement for wigs for hair loss related to chemotherapy up to $150 per year. Prior authorization is required.	You pay 20% of the total cost for wigs for hair loss related to chemotherapy. We will only pay up to a total of $150 for wig(s) for hair loss related to chemotherapy per year. If the wig(s) you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. Prior authorization is required.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you

should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

You will need to submit a new request for formulary exceptions each year.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30, 2016, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are in Section 8.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2016 (this year)	2017 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

For drugs on Tier 4 (Non-preferred Drugs), your cost-sharing in the initial coverage stage is changing from a copayment to coinsurance. Please see the following chart for the changes from 2016 to 2017.

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2016 (this year)	2017 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** For 2016 you paid a $95 copayment for drugs on Tier 4 (Non-preferred Drugs). For 2017 you will pay a 50% coinsurance for drugs on this tier. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $9 per prescription. *Preferred cost-sharing:* You pay $4 per prescription. **Tier 2 (Non-preferred Generic):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $45 per prescription. *Preferred cost-sharing:* You pay $40 per prescription. **Tier 4 (Non-preferred Brand):** *Standard cost-sharing:* You pay $95 per prescription. *Preferred cost-sharing:* You pay $90 per prescription. **Tier 5 (Specialty Tier):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-preferred Drugs):** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost.

	Once your total drug costs have reached $3,310, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For the Initial Coverage Stage, for drugs on Tier 4 (Non-preferred Drugs), your cost-sharing is changing from a copayment to coinsurance. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Other Changes

Cost	2016 (this year)	2017 (next year)
Medicare contract number	H0435	H3706
Pharmacy benefit manager	Express Scripts	CVS Caremark
Abdominal aortic aneurysm screening	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening. Prior authorization is not required.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening. Prior authorization is required.

Cost	2016 (this year)	2017 (next year)
Chiropractic services	You pay a $20 copay for Medicare-covered chiropractic services. Prior authorization is required.	You pay a $20 copay per visit for Medicare-covered chiropractic services. Prior authorization is not required.
Inpatient services covered during a non-covered inpatient stay	You pay the same copays or coinsurance for services as listed elsewhere in this benefit chart. Prior authorization is not required.	You pay the same copays or coinsurance for services as listed elsewhere in this benefit chart. Prior authorization is required.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Generations Premier (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2017.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2017*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, GlobalHealth, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Generations Premier (HMO)
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Premier (HMO)
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2017.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oklahoma, the SHIP is called Senior Health Insurance Counseling Program (SHIP).

Senior Health Insurance Counseling Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal

government to give **free** local health insurance counseling to people with Medicare. Senior Health Insurance Counseling Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Counseling Program (SHIP) at 1-800-763-2828. You can learn more about Senior Health Insurance Counseling Program (SHIP) by visiting their website (www.ship.oid.ok.gov).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications);
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HIV Drug Assistance Program (HDAP) at (405) 271-4636.

SECTION 8 Questions?

Section 8.1 – Getting Help from Generations Premier (HMO)

Questions? We're here to help. Please call Customer Care at (405) 280-5555 (local) or 1-844-280-5555 (toll-free). (TTY only, call 711.) We are available for phone calls 8:00 a.m. to 8:00 p.m., seven days a week, from October 1 – February 14, and 8:00 a.m. to 8:00 p.m. Monday – Friday from February 15 – September 30. Calls to these numbers are free.

Read your 2017 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2017. For details, look in the 2017 *Evidence of Coverage* for Generations Premier (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.globalhealth.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

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

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans”).

Read *Medicare & You 2017*

You can read the *Medicare & You 2017* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or 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.

Customer Care: 1-844-280-5555
TTY users call 711

8 a.m. to 8 p.m., 7 days a week (October 1 – February 14)
8 a.m. to 8 p.m., Monday – Friday (February 15 – September 30
www.GlobalHealth.com/medicare