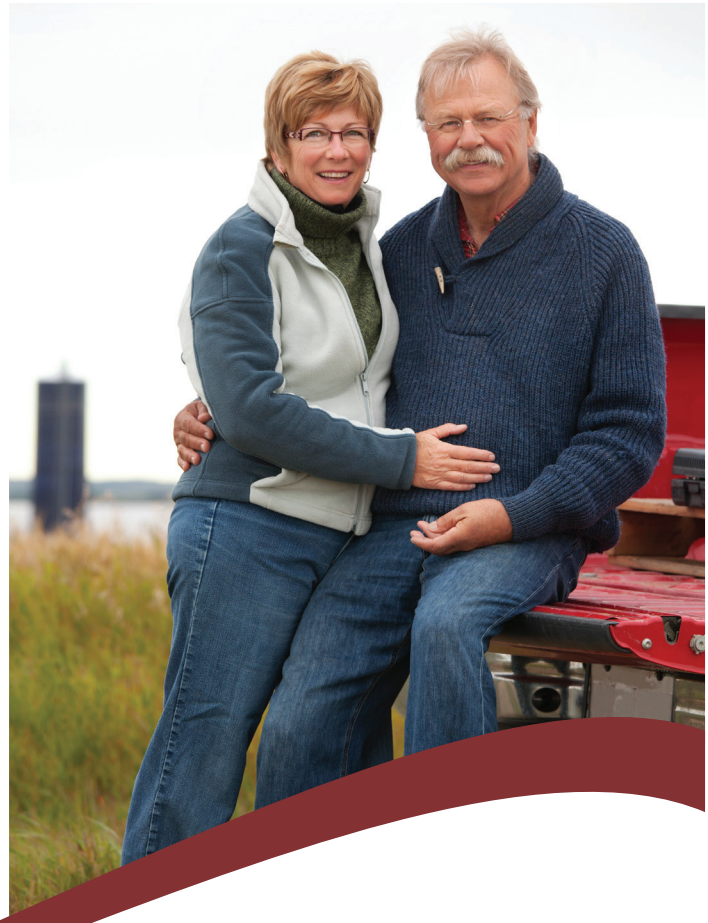
GlobalHealth

2017 All-In-One Guide

Plans starting as low as $0 a month



- Generations Value (HMO)
- Generations Classic (HMO)
- Generations Select (HMO)
- Generations Premier (HMO)

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal. You must continue to pay your Medicare Part B premium. 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.

H3706_AIOGUIDE_PY2017 Final Approved

Generations Medicare Advantage Plans, Offered by GlobalHealth

Table of Contents

Generations Medicare Advantage Plans, Offered by GlobalHealth

About GlobalHealth

- Local, Oklahoma-based health maintenance organization (HMO)
- Available in 44 counties
- 4 Generations Medicare Advantage plans
- Local Customer Care, Care Management and Pharmacy teams
- Thousands of quality providers, hospitals and pharmacies
- 3.5 Star Rating from Medicare for 2016

Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next.

What is a Medicare Advantage plan?
(Medicare Part C)

Medicare Advantage plans cover the same inpatient and outpatient services as original Medicare, including preventive care. Medicare Advantage plans may also offer additional coverage that Medicare does not have, such as prescription drug coverage. Medicare Advantage plans includes Medicare Part A, Part B and sometimes Part D.

Are You Eligible for Our Medicare Advantage Plans?

- **Must** be a permanent resident in our service area
- **Must** have both Medicare Part A and Part B
- **Must not** have End Stage Renal Disease (ESRD)

What Do You Know About Medicare?

The Four Parts of Medicare

PART A

Hospital Insurance

PART B

Medical Insurance

PART C

Medicare Advantage Plan
Includes Part A, Part B and sometimes Part D Coverage

PART D

Medicare Prescription Drug Coverage

Medicare Advantage Enrollment Dates

Pre-enrollment

Oct. 1 - Oct. 14
Compare plans so you are ready to enroll beginning Oct. 15th.

Annual Enrollment

Oct. 15 - Dec. 7
If you're eligible, you can join, switch or drop a Medicare Advantage plan.

Annual Disenrollment

Jan 1 - Feb. 14
Plan members may disenroll from their current plan and return to Original Medicare

Feb. 15 - Oct. 14
No plan changes unless special circumstances arise.

What Do You Know About Medicare?

Drug Payment Stages

DEDUCTIBLE STAGE	INITIAL COVERAGE STAGE	COVERAGE GAP STAGE	CATASTROPHIC COVERAGE STAGE
You pay the full cost of your drugs until you hit your deductible.*	The plan pays its share of the cost, and you pay your share (copayment/ coinsurance) until your total drug costs reach $3,700.	You will pay no more than 51% for covered generics or 40% on all other drugs until you reach $4,950.	You will pay the greater of 5% of the cost or $3.30 for generics and $8.25 for all other drugs.
Example: **Drug = $50** **You pay = $50**	Example: **Drug = $50** **Plan pays = $40** **You pay = $10**	Example: **Drug = $50** **Plan pays = 49% ($24.50)** **You pay = 51% ($25.50)**	Example: **Drug = $50** **Plan pays = $46.70** **You pay = $3.30**
$50 towards deductible*	$50 towards initial coverage limit	$25.50 towards coverage gap	

*No deductible on our plans.

What Do You Know About Medicare?

Need Extra Help? You May Qualify!

You may be able to get Extra Help, otherwise known as Low Income Subsidy (LIS), with your Medicare prescription drug plan premium and copay.

To find out if you qualify, call:

- Medicare: 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY: 1-877-486-2048).
- Social Security Office: 1-800-772-1213, 7:00 AM to 7:00 PM (TTY: 1-800-325-0778)
- State Medicaid (SoonerCare Helpline): 1-800-987-776

2017 Premium Subsidy Tables for Those Who Qualify for Extra Help

The premiums listed in the table below include coverage for both medical and prescription drug coverage (if applicable).

Your Extra Level of Help	Your Monthly Premium*			
	Generations Classic	Generations Value	Generations Select	Generations Premier
100%	$0	$0	$0	$80.50
75%	$0	$0	$7.50	$88.20
50%	$0	$0	$15.00	$95.90
25%	$0	$0	$22.50	$103.60

*You must continue to pay your Medicare Part B premium.

What Do You Know About Medicare?

Key Terms

- **Coinsurance:** An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).
- **Copayment (copay):** 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, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
- **Cost Share:** Cost-sharing refers to amounts that a member has to pay when services or drugs are received (for example, your copayment or coinsurance).
- **Deductible:** The amount you must pay for health care or prescriptions before our plan begins to pay.
- **Drug Formulary:** A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.
- **Maximum out-of-pocket (MOOP):** The most that you pay out-of-pocket during the calendar year for in-network covered services.
- **Network:** Group of contracted providers, facilities and pharmacies for the plan.
- **Premium:** The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.
- **Prior Authorization (Referral):** On certain services or drugs, you will need to get approval in advance from GlobalHealth before obtaining the services or drugs. Your Primary Care Physician (PCP) may submit a referral to GlobalHealth for the prior authorization. If you do not get prior authorization, GlobalHealth may not cover the services.

What Makes Us Different?

Being a Member Has Its Perks

Generations Medicare Advantage plans allow you to enjoy the benefits you currently receive from Original Medicare plus, vision and dental services, peace of mind emergency coverage and many more money-saving benefits! In fact, most of our plans include Part D prescription drug coverage.

We make it simple for you to get more out of Medicare.

$0* MONTHLY PREMIUM
Not applicable to all plans.

$0 PRIMARY CARE PHYSICIAN COPAY

NO COPAYS FOR PREVENTIVE SERVICES
such as colonoscopies, mammograms, diabetes screenings and more.

NO MEDICAL OR DRUG DEDUCTIBLES

$0 TIER 1 FOR PREFERRED GENERICS
on 90-day preferred mail order

3 MONTH SUPPLY OF PRESCRIPTION DRUGS*
**Not available on all tiers.*

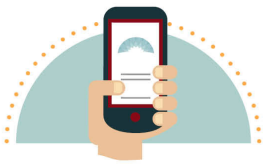
STRONG NETWORK

VISION BENEFITS

RIGHT HERE IN OKLAHOMA

WE PICK UP THE PHONE

GLOBALHEALTH CAFÉ



NEW MOBILE APP
helps you find benefit information.

Where is GlobalHealth?

Service Area

Generations Medicare Advantage plans are available in **44** Oklahoma counties. (see back cover of guide for complete service area)

Provider Network*

as of September 2016

Generations Medicare Advantage plans have a strong network of providers and facilities.

TULSA

- Harvard Family Physicians
- Utica Park Clinic Physician Group
- Hillcrest Medical Center
- Hillcrest South Hospital
- Hillcrest Hospital Claremore
- Tulsa Spine & Specialty Hospital
- Oklahoma Heart Institute
- Oklahoma Surgical Hospital
- OSU Medical Center, Mercy
- OSU Physicians
- Bailey Medical Center, Owasso
- Oklahoma Spine and Brain Institute

OKLAHOMA CITY

- Oklahoma City Clinic
- Mercy Hospital
- Mercy Primary Care Clinics
- Integris Baptist Medical Center
- Integris Health Edmond
- Integris Southwest Medical Center
- Integris Primary and Specialty Care Clinics
- Oklahoma Heart Hospitals
- Bone and Joint Hospital at St. Anthony
- St. Anthony Hospital
- Variety Care Clinic
- Mary Mahoney Health Center

*Other providers are available in our network. To see if your local provider or hospital is in network, visit www.GlobalHealth.com/search or call Customer Care at 1-844-280-5555.

Medicare Star Ratings

What are Star Ratings?

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to Medicare health and prescription drug plans.

Why are Star Ratings important to me?

These ratings help you compare plans based on quality and performance. A plan can get a rating from one to five stars. A 5-star rating is considered excellent. The overall plan rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance.

What do the plan ratings measure?

For plans covering health services, the overall score for quality of those services covers 36 different topics in five categories:

- Staying healthy
- Managing chronic (long-term) conditions
- Ratings of health plan responsiveness and care
- Health plan member complaints and appeals
- Health plan telephone customer service

For plans covering drug services, the overall score for quality of those services covers 17 different topics in four categories:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

Learn More About Plan Ratings

Visit the Medicare Plan Finder Tool on www.medicare.gov to learn more about plans and see their ratings. You can find a plan's overall rating on the Plan Results page or view a complete summary of all plan's quality and performance ratings by clicking "Plan Ratings" on the Plan Results page.

GlobalHealth Star Ratings

GlobalHealth - H3706

2017 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.

2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2017, GlobalHealth received the following Overall Star Rating from Medicare.


3.5 Stars

We received the following Summary Star Rating for GlobalHealth's health/drug plan services:

Health Plan Services:	 3.5 Stars
Drug Plan Services:	 3 Stars

The number of stars shows how well our plan performs.

	5 stars - excellent
	4 stars - above average
	3 stars - average
	2 stars - below average
	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time at 844-280-5555 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

Current members please call 844-280-5555 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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

2017 Benefits at a Glance

Generations Medicare Advantage Plans, Offered by GlobalHealth

Effective January 1, 2017 – December 31, 2017

	MA-ONLY	MAPD		
	GENERATIONS VALUE (HMO)	GENERATIONS CLASSIC (HMO)	GENERATIONS SELECT (HMO)	GENERATIONS PREMIER (HMO)
BENEFIT	**YOU PAY**			
Premium	$0	$0	$30	$111.30
Deductible	$0	$0	$0	$0
MOOP	$3,000	$3,300	$3,400	$4,500
Primary Care Physician	$0	$0	$0	$0
Specialist	$25 copay	$40 copay	$45 copay	$30 copay
Preventive Care	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Inpatient Hospital Care	$250 copay per day (Days 1–6) You pay nothing per day (Days 7–190)	$365 copay per day (Days 1–5) You pay nothing per day (Days 6–190)	$300 copay per day (Days 1–8) You pay nothing per day (Days 9–90)	$275 copay per day (Days 1–3) You pay nothing per day (Days 4–190)
Outpatient Surgery and Hospital Services	$250 copay	$250 copay – Ambulatory or Preferred Facility $320 copay – Non-Preferred Facility	$250 copay – Ambulatory or Preferred Facility $350 copay – Non-Preferred Facility	$125 copay – Ambulatory or Preferred Facility $250 copay – Non-Preferred Facility
Diagnostic Tests, X-rays, Lab Services and Radiology	20% coinsurance	$10 copay for labs and x-rays; $40 copay for therapeutic radiology	You pay nothing for labs and x-rays; 20% coinsurance for therapeutic radiology	You pay nothing for labs and x-rays; $30 copay for therapeutic radiology
MRI, PET, CT Scans	20% coinsurance	$150 copay	$150 copay	$0-$200 copay
Ambulance Services	$100 copay	$100 copay	$250 copay	$50 copay
Emergency Room	$75 copay	$75 copay	$75 copay	$50 copay
Urgent Care	$25 copay	$30 copay	$45 copay	$35 copay

2017 Benefits at a Glance

Prescription Drug Coverage

Effective January 1, 2017 – December 31, 2017

Generations Classic, Generations Select, Generations Premier
Deductible: $0

Note: Generations Value does not include Prescription Drug Coverage

	GENERATIONS CLASSIC, SELECT & PREMIER		
Drug Type	30-Day Supply at Preferred Retail Pharmacy	90-Day Supply from Mail Order Pharmacy*	30-Day Supply from Standard Retail Pharmacy
Tier 1 – Preferred Generics	$5	$0	$10
Tier 2 – Generics	$15	$15	$20
Tier 3 – Preferred Brand Name	$42	$84	$47
Tier 4 – Non-Preferred	40%	30%	50%
Tier 5 – Specialty	33%	N/A	33%
Coverage Gap Stage After your prescription costs reach $3,700		Your costs will be no more than 51% of the cost for generic drugs. You pay 40% of the cost of brand name drugs	
Catastrophic Coverage Stage After you have paid $4,950 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.30 for generics/ $8.25 for brand names.	

*Costs for 90-day supply are higher at Standard Retail Pharmacy

2017 Benefits at a Glance

Additional Benefits Not Covered Under Original Medicare

Effective January 1, 2017 – December 31, 2017

GENERATIONS VALUE	
Podiatry Services – Foot Care	$25 copay (covered under Original Medicare)
Routine Vision Exam	You pay nothing for up to 1 visit per year
Routine Eyewear Benefit	You pay nothing; plan pays up to a $200 calendar year maximum
Dental/Dentures	You pay nothing for preventive services.
GENERATIONS CLASSIC	
Podiatry Services – Foot Care	$40 copay (covered under Original Medicare)
Routine Vision Exam	$20 copay for up to 1 visit per year
Routine Eyewear Benefit	20% coinsurance; plan pays up to a $205 calendar year maximum
Dental/Dentures	You pay nothing for cleaning and x-rays. $5 copay for oral exams
GENERATIONS SELECT	
Podiatry Services – Foot Care	$40 copay (covered under Original Medicare)
Routine Vision Exam	$45 copay for up to 1 visit per year
Routine Eyewear Benefit	$45 copay for frames and lenses; Plan pays up to a $200 calendar year maximum
Dental/Dentures	You pay nothing for cleaning and x-rays. $5 copay for oral exams
GENERATIONS PREMIER	
Podiatry Services – Foot Care	$30 copay (covered under Original Medicare)
Routine Vision Exam	$45 copay for up to 1 visit per year
Routine Eyewear Benefit	You pay nothing; plan pays up to a $200 calendar year maximum
Dental/Dentures	You pay nothing for preventive services; 50% coinsurance for dentures; Plan pays up to a $500 calendar year maximum

For more information call 1-844-280-5555, 8:00 a.m. to 8:00 p.m. (TTY users call 711) 7 days a week, or visit us on the web at www.GlobalHealth.com/medicare.

GlobalHealth

2017 Summary of Benefits

January 1 – December 31, 2017

Generations Value (HMO)

Generations Classic (HMO)

Generations Select (HMO)

Generations Premier (HMO)

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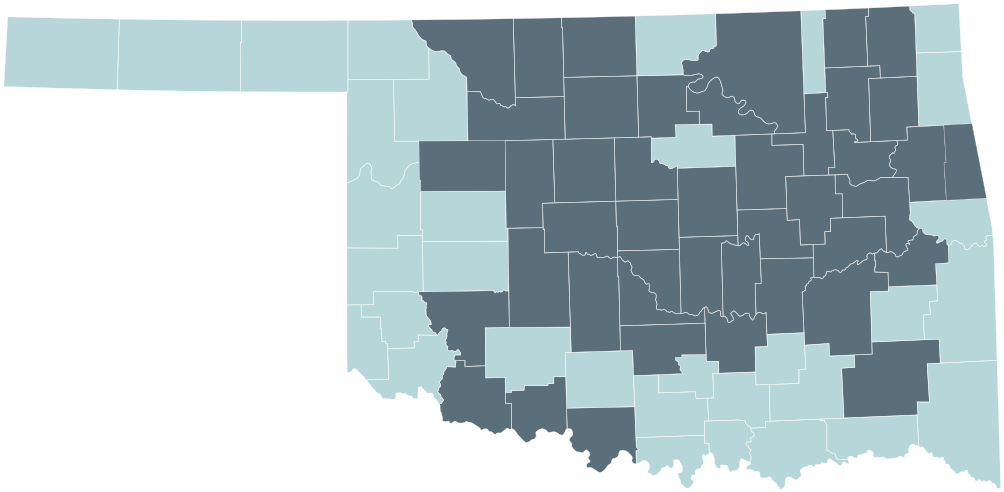
1-844-280-5555 (TTY users call 711)
8 a.m. to 8 p.m., 7 days a week
www.GlobalHealth.com/medicare

H3706_SB_PY2017 Accepted

This is a summary of drug and health plan services covered by GlobalHealth January 1, 2017 – December 31, 2017.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

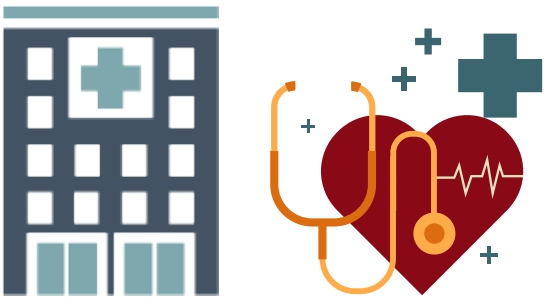
To join GlobalHealth, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Oklahoma:



Adair	Garfield	Major	Pawnee
Alfalfa	Garvin	Mayes	Pittsburg
Blaine	Grady	McClain	Pontotoc
Caddo	Grant	McIntosh	Pottawatomie
Canadian	Haskell	Muskogee	Pushmataha
Cherokee	Hughes	Noble	Rogers
Cleveland	Jefferson	Nowata	Seminole
Cotton	Kingfisher	Okfuskee	Tillman
Craig	Kiowa	Oklahoma	Tulsa
Creek	Lincoln	Okmulgee	Wagoner
Dewey	Logan	Osage	Woods

GlobalHealth 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.

2017
Medicare Advantage (MA-Only) Plan
(No Medicare Part D)



January 1, 2017 – December 31, 2017

Generations Value (MA) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,000 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $250 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $25 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $25 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay 20% of the cost • You pay $20 copay per visit • You pay $20 copay per visit • You pay 20% of the cost • You pay 20% of the cost	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for lab services, diagnostic tests and procedures, therapeutic radiology or outpatient x-rays is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $25 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay nothing • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam (1 per year)** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay nothing • You pay nothing • You pay 20% of the cost	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit** [1,2] • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $250 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $10 copay per visit • You pay $10 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $105 for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $25 copay per visit • You pay $25 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $100 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) [1,2] • **Foot exams and treatment** • **Routine foot care**	• You pay $25 copay per visit • You pay $25 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies [1,2] • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics and related supplies (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices & medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing for preferred brand monitoring supplies • You pay 20% of the cost for non-preferred brand monitoring supplies	See the drug formulary for preferred/non-preferred status of monitoring supplies.
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Our plan does not cover Part D prescription drugs. Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

2017
Medicare Advantage
Prescription Drug (MA-PD) Plans

Generations Classic (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,300 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $365 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $40 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $30 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay $10 copay per visit • You pay $10 copay per visit • You pay $40 copay per visit • You pay $10 copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for lab services, diagnostic tests and procedures, therapeutic radiology or outpatient x-rays is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $40 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay $5 copay per exam • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay $20 copay per visit • You pay 20% of the cost • You pay 20% of the cost	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $205 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit** [1,2] • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $279 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $20 copay per visit • You pay $20 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $150 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $40 copay per visit • You pay $40 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $100 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) [1,2] • **Foot exams and treatment** • **Routine foot care**	• You pay $40 copay per visit • You pay $40 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies [1,2] • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics and related supplies (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing for preferred brand monitoring supplies • You pay 20% of the cost for non-preferred brand monitoring supplies	See the drug formulary for preferred/non-preferred status of monitoring supplies.
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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

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

Generations Select (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $30	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $300 copay per day for days 1 through 8 • You pay nothing per day for days 9-90	
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $45 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $45 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay nothing • You pay nothing • You pay 20% of the cost • You pay nothing	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for therapeutic radiology is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $50 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay $5 copay per visit • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay $45 copay per visit • You pay $45 copay per visit • You pay $45 copay per pair • You pay nothing	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $300 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $20 copay per visit • You pay $20 copay per visit	
Skilled Nursing Facility [1,2]	• You pay $10 copay per day for days 1 through 20 • $160 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $40 copay per visit • You pay $40 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	

1 = Prior Authorization Required
2 = Referral Required

Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $40 copay per visit • You pay $40 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.
PREMIUMS AND BENEFITS	**GENERATIONS SELECT**	**WHAT YOU SHOULD KNOW**
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing	
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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

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

Generations Premier (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $111.30	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$4,500 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $275 copay per day for days 1 through 3 • You pay nothing per day for days 4-190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $30 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Emergency Care	You pay $50 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $35 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay nothing • You pay nothing • You pay $30 copay per visit • You pay nothing	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for therapeutic radiology is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam [1,2]** • **Supplemental exam (1 per year)**	• You pay nothing • You pay $25 copay per visit • You pay $20 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay nothing • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay $45 copay per visit • You pay $45 copay per visit • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $325 copay per day for days 1 through 3 • You pay nothing per day for days 4 through 190 • You pay nothing • You pay nothing	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $50 copay per days for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $25 copay per visit • You pay $25 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $50 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• $30 copay • $30 copay	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing	
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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

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

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

Provider & Pharmacy Directory:
www.GlobalHealth.com/search

Some of our plans cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.GlobalHealth.com/medicare.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

ENROLL

GENERATIONS MEDICARE ADVANTAGE PLANS, OFFERED BY GLOBALHEALTH.

Understanding Enrollment Periods

Annual Election Period (October 15, 2016 – December 7, 2016)

- Switch, drop or join a Medicare Advantage plan of your choosing

Medicare Advantage Disenrollment Period (January 1, 2017 – February 14, 2017)

- For Medicare Advantage plans, you can leave your plan and switch to Original Medicare
  – If you switch to Original Medicare, you can sign up for a standalone Prescription Drug Plan until February 14, 2017
- During this period you cannot do the following:
  – Switch from Original Medicare to a Medicare Advantage plan
  – Switch from one Medicare Advantage plan to another

SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
ENROLL (October 15 – December 7)				DISENROLL You cannot change your 2016 coverage after Feb 14*(January 1 – February 14)							
SPECIAL ELECTION PERIOD (YEAR-ROUND)											

Q: If you answer yes to any of the following questions, you may be eligible for a Special Election Period

Q: Have you recently moved and are new to Medicare?

Q: Are you currently receiving Extra Help with your healthcare costs?

Q: Do you no longer qualify for Extra Help with your healthcare costs?

Q: Have you recently left a PACE program (Program of All-inclusive Care for the Elderly)?

Q: Are you leaving employer or union coverage?

Q: Do you live in a long-term care facility?

Q: Will you be moving into a long-term care facility?

Q: Have you recently moved out of a long-term care facility?

*Unless you qualify for a Special Election Period

Enrolling in a Generations Medicare Advantage Plan

Follow these easy steps to enroll in a Generations Medicare Advantage plan.

1. Each applicant must fill out a separate enrollment form.
2. Have your Medicare card ready. You will need to fill in the requested information EXACTLY as it appears on your Medicare card to avoid delays with your enrollment.
3. Sign and date the enrollment form. Your enrollment form is not complete without a signature.

There are three easy ways to submit your enrollment:

Local sales agent:
Contact your local sales agent to help you choose the right plan for you and to complete your enrollment.

Enroll online:
You have the option to enroll online on our website:
www.GlobalHealth.com/medicare

Call us:
If you need assistance in filling out your enrollment form or wish to enroll by phone, call us at 1-844-280-5555, 8:00 a.m. to 8:00 p.m. (TTY users call 711) 7 days a week. We'll be glad to help.

or Mail:
Fill out this paper enrollment form and mail it, along with any other required documentation to:

GlobalHealth
Attn: Eligibility and Enrollment
P.O. Box 1747
Oklahoma City, OK 73101-1747

Please do not submit your enrollment information more than once to avoid delays with your enrollment.

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Generations Medicare Advantage Plans, Offered By GlobalHealth

Individual Enrollment Request Form (For New Members Only)

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ❑ I am new to Medicare.
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on __/__/____
- ❑ I recently was released from incarceration. I was released on. __/__/____
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on __/__/____
- ❑ I recently obtained lawful presence status in the United States. I got this status on __/__/____
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❑ I get extra help paying for Medicare prescription drug coverage.
- ❑ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on __/__/____
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on __/__/____
- ❑ I recently left a PACE program on __/__/____
- ❑ I recently involuntarily lost my credible prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on __/__/____
- ❑ I am leaving employer or union coverage on __/__/____
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on __/__/____

If none of the statements apply to you or you're not sure, please contact GlobalHealth at 405-280-5555 or 844-280-5555 (TTY users call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week.

Generations Medicare Advantage Plans, Offered By GlobalHealth

Individual Enrollment Request Form (For New Members Only)

Please contact GlobalHealth is you need information in another language or format

SECTION 1	To Enroll in a Generations Medicare Advantage Plan Please Provide the Following Information:

Please check which Generations Medicare Advantage plan you want to enroll in:

- ❑ $0 Generations Value
- ❑ $0 Generations Classic
- ❑ $30 Generations Select
- ❑ $111.30 Generations Premier

Last Name: | First Name: | MI: | ❑ Mr. ❑ Mrs. ❑ Ms.

Birth Date: M M / D D / Y Y Y Y | Sex: ❑ M ❑ F | Home Phone Number: ___ – ___ – ____ | Alternate Phone Number: ___ – ___ – ____

Permanent Residence Street Address (P.O. Box is not allowed):

City: | State: | ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street Address:

City: | State: | ZIP Code:

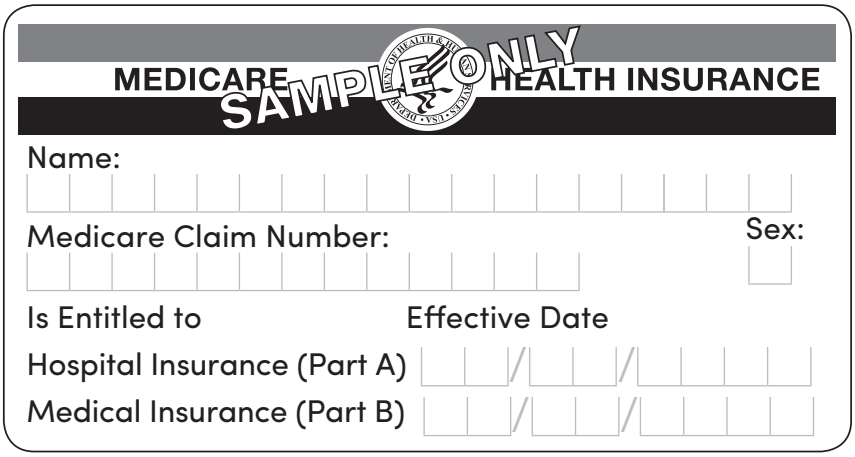
SECTION 2	Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

Please fill in these blanks so they match your red, white and blue Medicare card. -OR-

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have both Medicare Part A and Part B to join a Medicare Advantage plan.



For **Generations Value**, please continue to Section 4 of this application.

For **Generations Classic:**
If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail, Electronic Funds Transfer, know (EFT), or credit card each month. You can also choose to pay your late enrollment penalty by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your late enrollment penalty. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay GlobalHealth the Part D-IRMAA.

For **Generations Select** or **Generations Premier**:
You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay GlobalHealth the Part D-IRMAA.

For **Generations Classic, Select** or **Premier**:
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 co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at: www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your prescription drug premium. If Medicare only pays a portion of this premium, you will be billed for the amount Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.
Please select a payment option:

❑ Get a Bill

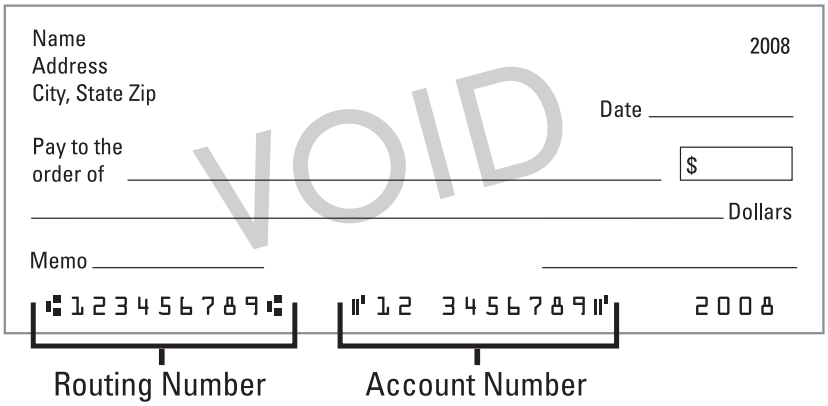
❑ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account Holder Name:

Bank Routing Number:

Bank Account Number:

Account Type: ❑ Checking ❑ Savings



❑ Credit Card. Please provide the following information:

Type of Card:

Name of Account Holder as it appears on card:

Account Number

Expiration Date: /

❑ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

PLEASE ATTACH VOIDED CHECK HERE

SECTION 4 — Please Read and Answer These Important Questions:

1. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No

If you have had a successful kidney transplant and/or you do not need regular dialysis anymore, please attach a note or records from your physician showing you have had a successful kidney transplant or you do not need dialysis, otherwise we may need to contact you to obtain additional information.

Please complete this section if you have selected a MA-PD plan.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to a Generations plan?

❑ Yes ❑ No

If 'yes,' please list your other coverage and your identification (ID) number (s) for this coverage:

Name of Other Coverage:

ID # for This Coverage:

Group # for This Coverage:

3. Are you a resident in a long-term care facility, such as a nursing home? ❑ Yes ❑ No

If 'yes,' please provide the following information:

Name of Institution:

Address of Institution (number and street):

City: State: ZIP Code:

Phone Number: – –

4. Are you enrolled in your State Medicaid program? ❑ Yes ❑ No

If 'yes,' please provide your Medicaid number:

5. Do you or your spouse work? ❑ Yes ❑ No

6. Please choose the name of a Primary Care Physician (PCP), clinic or health center:

7. Please check the box below if you would prefer us to send you information in another format:

❑ Large Print

Please contact GlobalHealth at 1-844-280-5555 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. to 8:00 p.m. (TTY users call 711) 7 days a week.

SECTION 5 — STOP Please Read This Important Information STOP

If you currently have health coverage from an employer or union, joining a GlobalHealth MA-PD plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a GlobalHealth MA-PD plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

SECTION 6	Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

GlobalHealth is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. (**For Generations Value Plan Only**: I understand that if I don't have Medicare prescription drug coverage, or credible prescription drug coverage (as good as Medicare's), I may have to pay a late penalty if I enroll in Medicare prescription drug coverage in the future.) Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available. (Example: October 15 – December 7 of every year), or under certain special circumstances.

GlobalHealth serves a specific service area. If I move out of the area that GlobalHealth serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of GlobalHealth, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from GlobalHealth when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date GlobalHealth coverage begins, I must get all of my healthcare from GlobalHealth, except for emergency or urgently needed services or out of area dialysis services. Services authorized by GlobalHealth and other services contained in my GlobalHealth Evidence of Coverage document (also known as member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GLOBALHEALTH WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with GlobalHealth, he/she may be paid based on my enrollment in GlobalHealth.

Release of Information: By joining the Medicare health plan, I acknowledge that GlobalHealth will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that GlobalHealth will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment for is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

SECTION 6 (cont.)	Please Read and Sign Below:
Signature:	Today's Date: ___/___/_____

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

City: State: ZIP Code:

Phone Number: – –

Relationship to Enrollee: ❑ Child ❑ Friend ❑ Spouse ❑ Other_____

Member Material Delivery Preference

I wish to receive my member materials by:

❑ Email

OR

❑ Mail

If you opt-in to receive your member materials by email, you will NOT receive a copy in the mail unless requested. By opting in for emailed member materials, you will not be subscribing to emails from GlobalHealth.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID Number: Effective Date of Coverage: ___/___/_____

Agent Signature:_____

ICEP/IEP: AEP: SEP(Type):

Not Eligible:

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

H3706_ENROLLMENTFORM_PY2017 APPROVED

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Generations Medicare Advantage Plans, Offered by GlobalHealth

Receipt of Enrollment

To be filled out by Agent.

Confirmation #: _____

Application Date: ___/___/_____

Proposed Effective Date: ___/___/_____

Plan Name: _____

Agent Name: _____

Agent Phone Number: ___—___—_____

Agent ID: _____

This document verifies you met with an agent and completed an Enrollment Request Form for a Generations Medicare Advantage plan, offered by GlobalHealth. Upon confirmation of your enrollment, you will receive important plan information such as your Member ID Card and a Welcome Kit that will include your Evidence of Coverage.

Please tear out to keep for your records.

If you have any questions regarding your plan benefits, contact Customer Care at **1-844-280-5555, 8:00 a.m. to 8:00 p.m., (TTY users call 711) 7 days a week.**

Beneficiary Signature: _____ Date: _____

Agent Signature: _____ Date: _____

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AGENT ENROLLMENT ATTESTATION

Instructions: Agent, complete and retain this with the SOA.

By initialing the boxes below and signing this form, I attest to each of the following.

1. ☐ Enrollment form is complete and accurate; correct plan selected.
2. ☐ Reviewed Summary of Benefits with enrollee including premium, covered benefits, and applicable deductibles, coinsurance, and copays.
3. ☐ Reviewed Formulary and drug tiers and Coverage Gap.
4. ☐ Enrollee voices understanding of benefits, including Prescription Drug Coverage.
5. ☐ Reviewed Provider Directory with enrollee and "in-network" requirements.
6. ☐ Beneficiary voices understanding that plan requires prior authorization and does not cover out-of-network services except in emergency situations.
7. ☐ Reviewed Primary Care Physician (PCP) requirements and referral process.
8. ☐ Enrollee voices understanding that he/she must continue to pay the Part B Premium.
9. ☐ Enrollee voices understanding of how he/she will make monthly premium payments, if applicable.
10. ☐ Notified enrollee to expect an enrollment confirmation letter from the plan.
11. ☐ Advised enrollee to use the new ID card from GlobalHealth rather than the Medicare red, white, and blue card beginning with enrollment effective date.
12. ☐ Reviewed late enrollment penalty (LEP), if applicable.
13. ☐ Answered enrollee's questions and advised him/her to review plan materials carefully.

Enrollee Name _____

Agent Name _____

Agent Signature _____ Date _____

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After Enrollment What Happens Next?

Welcome to the GlobalHealth family! After you enroll in your Generations Medicare Advantage plan, offered by GlobalHealth, use the checklist below to know what to expect next.

STEP		HOW YOU RECEIVE THIS	WHY YOU RECEIVE THIS
1	Enrollment Verification Letter	 Mail	To assure you that we received your completed enrollment form. (Please note: Medicare still must approve your enrollment.)
2	Welcome Kit	 Mail	To provide you with a Welcome Kit that has plan information, including your Evidence of Coverage.
3	Member ID Card	 Mail	To provide you with a Member ID card. You need to show this card every time you visit the physician, hospital or pharmacy (if applicable).
4	Notice to confirm your enrollment	 Mail	To confirm your enrollment was approved by Medicare.
5	Health Risk Assessment (HRA)	 Mail	This information will allow GlobalHealth to coordinate with your health care providers in a way that best services your preventive health care needs.

QUESTIONS? You can call our friendly Customer Care for answers to your questions from 8am-8pm, 7 days a week, 1-844-280-5555, TTY call 711.

How to Easily Access Your Benefit Information

Looking for other ways to view your plan cost shares and other information included in your plan? Below are additional ways to view your plan benefits.

Download the GlobalHealth Mobile App

The GlobalHealth app provides access to GlobalHealth member information and resources as well as enrollment reminders and updates from GlobalHealth.

Visit your app store today to download the GlobalHealth mobile app or visit www.GlobalHealth.com/mobileapp.

Download on the App Store

GET IT ON Google Play

Visit the GlobalHealth Website

Our website includes the below information for quick and easy access. Visit www.GlobalHealth.com/medicare today.

- Find a provider or pharmacy
- Cost shares (copayments/coinsurance)
- Dental benefits
- Enroll in prescription drug mail order
- View Evidence of Coverage (EOC)
- Summary of Benefits
- Prescription drug forms

Important Phone Numbers

Questions about your plan benefits? You can call Customer Care for answers to your questions. If you suspect Medicare fraud, waste or abuse, call our hotline. Keep this list handy, so you always know who to call.

IMPORTANT PHONE NUMBERS:	WHY CALL?
Customer Care **1-844-280-5555** **8:00 a.m. to 8:00 p.m. (TTY users call 711) 7 days a week**	**Speak to a Member Advocate:** • If you've lost important plan documents, like your Member ID card or your Summary of Benefits. • If you need to obtain authorization for a service or procedure. • If you need to know if a specific procedure or service is covered. • When you are going to be or have been admitted to the hospital. • When you have had an emergency and gone to the emergency room. • When you are being discharged from a hospital stay. • If you have questions about: – Home healthcare – Durable Medical Equipment – Behavioral Health Services
Fraud, Waste, and Abuse Hotline **1-877-280-5852** **All communications are confidential and anonymous.**	**Report any healthcare fraud, such as:** • Provider bills you for medical services, supplies or items that were not provided. • Provider performs medically unnecessary services to obtain the insurance payment. • Someone steals your personal information to submit false claims to obtain the insurance benefit. • Someone pretends to represent Medicare, the Social Security Administration or an insurance plan for the purpose of obtaining personal information.

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CVS caremark™

Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 94467
PALATINE, IL 60094-4467

GlobalHealth Member ID # (on GlobalHealth ID card)

GlobalHealth

Please fold here →

Instructions:

Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call our toll-free number 1-866-494-3927.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

* WEB *

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

C **Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

First person with a refill or new prescription. ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of birth: MM-DD-YYYY

E-mail address: | Date new prescription written:

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other:

Second person with a refill or new prescription. ○ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

NICKNAME | Gender: ○ M ○ F | Date of birth: MM-DD-YYYY

E-mail address: | Date new prescription written:

Doctor's last name | Doctor's first name | Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid reflux ○ Glaucoma ○ Heart problem ○ High blood pressure ○ High cholesterol ○ Migraine ○ Osteoporosis ○ Prostate issues ○ Thyroid ○ Other:

D **Special instructions:**

E **How would you like to pay for this order?** (If your copay is $0, you do not need to provide payment information.)

○ **Electronic check.** Pay from your bank account. (You must first register online at www.caremark.com or call Customer Care at 1-866-494-3927.)

○ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Use your card on file.

○ Use a new card or update your card's expiration date.

Exp.Date MMYY

Credit card holder signature/Date

○ **Check or money order.** Amount: $.

- Make check or money order payable to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

○ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

○ **2nd business day ($17)**

○ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

MOF WEB 0316 GLOBALHEALTH

Please fold here → * WEB *

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GlobalHealth
Transition of Care Request Form

This form must be completed if you are currently under a different health insurance plan even if your current health care provider is also a GlobalHealth provider. Some specialists and facilities that you currently use may not be in the GlobalHealth network.

INSTRUCTIONS FOR COMPLETING TRANSITION OF CARE REQUEST FORM

A separate Transition of Care Request Form must be completed for each condition for which you are seeking Transition of Care benefits. Photocopies of this form are acceptable. Please make sure all questions are answered completely. Attach additional information if necessary. When the form has been completed, the patient for whom Transition of Care benefits have been requested, should sign it.

To help ensure timely review, please mail this form as soon as possible to the address shown on the back.

Patient's Name	Date of Birth (mm/dd/yyyy)	Social Security #
Date of Enrollment in GlobalHealth (mm/dd/yyyy)	Policy #	Home Phone #
Home Address City State Zip		Alternate Phone #

1. Is the patient pregnant and in the second or third trimester of pregnancy? ☐ Yes ☐ No
   If yes, when is the due date? (mm/dd/yyyy)_____
2. Is the patient currently receiving treatment for any acute conditions or trauma? ☐ Yes ☐ No
3. Is the patient scheduled for surgery or hospitalization after the effective date with GlobalHealth? ☐ Yes ☐ No
4. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate for Organ Transplant? ☐ Yes ☐ No
5. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
6. Is the patient receiving mental health/substance abuse care? ☐ Yes ☐ No
7. If you did ***not*** answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care in the space provided below.

Treating Physician's Group Practice Name (if known)	
Physician's Name	Physician's Phone #

GlobalHealth Transition of Care Request Form (cont.)

Physician's Specialty		
Address of Physician		
Name of Hospital at Which the Physician Practices	Hospital's Phone #	
Address of Hospital		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

8. Is the patient expected to be in the hospital when coverage with GlobalHealth begins or within the next 60 days? ☐ Yes ☐ No
9. GlobalHealth Primary Care Physician's Name

_____

Describe conditions from question #7 requiring transition of care:

I hereby authorize the above named physician(s) to provide GlobalHealth with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. The authorization will expire 24 months from the date signed. I understand I may revoke this authorization at any time by writing to the address listed at the bottom of this form. I understand that I cannot restrict information that may have already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.	
Signature of Patient	Date (mm/dd/yyyy)

PLEASE SEND THIS FORM TO:
GlobalHealth
Utilization Management
P.O. Box 2328
Oklahoma City, OK 73101-2328

Multi-Language & Non-Discrimination Notice

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- 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 GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free).

If you believe that GlobalHealth 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: **ATTN: Compliance Attorney, 701 NE 10th Street, Suite 300, Oklahoma City, OK 73104-5403, Fax: (405) 280-5894, or Email: compliance@globalhealth.com.** You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

H3706_MLI_2017 Accepted

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).

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 1-844-280-5555 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-280-5555 (TTY: 711)번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-280-5555 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-280-5555 (رقم هاتف الصم والبكم: 117).

သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-844-280-5555 (TTY: 711) သုိ႔ ေခၚဆိုပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-280-5555 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-280-5555 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-280-5555 (ATS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-280-5555 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-280-5555 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844-280-5555 (TTY: 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-844-280-5555 (TTY: 711).

هجوت: اگر هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-844-280-5555 (TTY: 711).

H3706_MLI_2017 Accepted

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires Sales Agents and Brokers to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by the Medicare beneficiary or his/her authorized representative.

Please initial beside the type of product(s) you want to discuss.

_____ Medicare Advantage Plan (Part C only)

_____ Medicare Advantage and Prescription Plan (Part C and D)

By signing this form, you agree to a meeting with a Sales Agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by GlobalHealth. He/she does **not** work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature	Signature Date
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (Last, First, MI)	Relationship to Beneficiary
If scope of appointment was not signed PRIOR to appointment: Reason:	

Scope of Sales Appointment Confirmation Form (cont.)

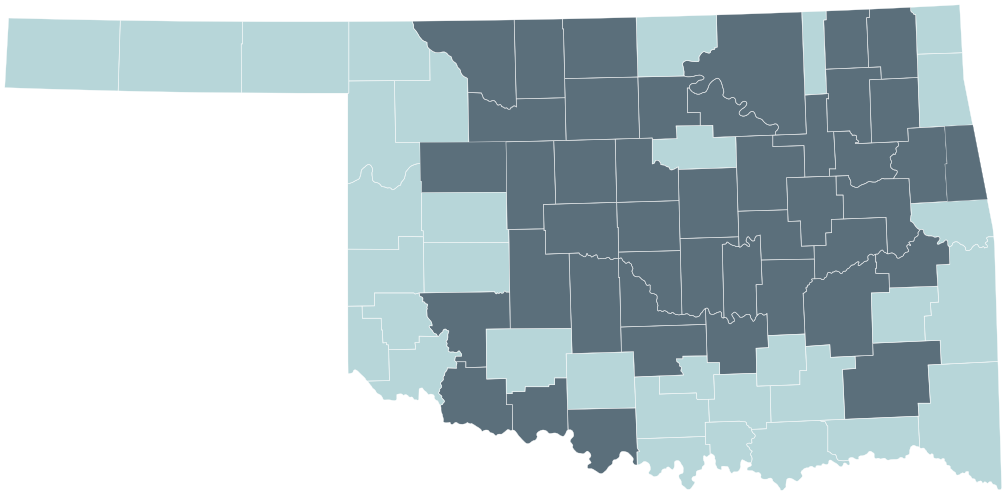
Agent Certification: By signing this form, I attest that during this appointment, I discussed only those products requested by the above beneficiary or authorized representative. This Scope of Appointment ("SOA") form is subject to CMS record retention requirements.

To be completed by Agent (please print clearly and legibly)		
Agent Name (First, MI, Last)	Agent Phone	Agent ID
Beneficiary Name (Last, First, MI)	Beneficiary Phone (optional)	Date Appointment Completed
Beneficiary Address (optional)		
Initial Method of Contact (e.g., walk-in, call-in, event)	Plan(s) the agent represented during the meeting	
Agent's Signature		

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

H3706_SOA_PY2017 Accepted

2017 Service Area



Adair	Garfield	Major	Pawnee
Alfalfa	Garvin	Mayes	Pittsburg
Blaine	Grady	McClain	Pontotoc
Caddo	Grant	McIntosh	Pottawatomie
Canadian	Haskell	Muskogee	Pushmataha
Cherokee	Hughes	Noble	Rogers
Cleveland	Jefferson	Nowata	Seminole
Cotton	Kingfisher	Okfuskee	Tillman
Craig	Kiowa	Oklahoma	Tulsa
Creek	Lincoln	Okmulgee	Wagoner
Dewey	Logan	Osage	Woods

GlobalHealth

Customer Care
1-844-280-5555 (TTY users call 711)
8 a.m. to 8 p.m., 7 days a week
www.GlobalHealth.com/medicare

Fraud, Waste and Abuse: GlobalHealth is committed to fighting healthcare fraud, waste and abuse. If you suspect Medicare fraud, waste or abuse, call our hotline — 1-877-280-5852.

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal. Your call may be answered by a licensed agent. You must continue to pay your Medicare Part B premium.