GlobalHealth

Annual Notice of Changes

January 1 – December 31, 2018

Generations Value (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_VALUEEOC_V2_2018 File & Use 09/07/2017 Accepted

Generations Value (HMO) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2018

You are currently enrolled as a member of Generations Value (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.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1.4 for information about benefit and cost changes for our plan.

☐ 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 Section 1.3 for information about our *Provider 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 and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.

- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan

   - If you want to **keep** Generations Value (HMO), you don't need to do anything. You will stay in Generations Value (HMO).
   - To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

   - If you **don't join by December 7, 2017**, you will stay in Generations Value (HMO).
   - If you join by December 7, 2017, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- 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 am to 8:00 pm, seven days a week, from October 1 – February 14, and 8:00 am to 8:00 pm Monday – Friday from February 15 – September 30.
- Customer Care has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is also available in large print.
- **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.

About Generations Value (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 Value (HMO).

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Generations Value (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	2017 (this year)	2018 (next year)
Monthly plan premium	$0	$0
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 1.2 for details.)	$3,000	$3,000
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $25 per visit	Primary care visits: $0 per visit Specialist visits: $40 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 $250 copay per day for days 1 through 6. There is no coinsurance, copayment, or deductible for days 7 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.	You pay a $250 copay per day for days 1 through 5. There is no coinsurance, copayment, or deductible for days 6 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

Section 1.2 – 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	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$3,000	$3,000 Once you have paid **$3,000** out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider 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 Directory*. **Please review the 2018 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are 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.
- We will make a good faith effort to 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 1.4 – 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 2018 *Evidence of Coverage*.

Cost	2017 (this year)	2018 (next year)
Cardiac rehabilitation services	You pay a $25 copay per visit for Medicare-covered cardiac rehabilitation services. You pay a $25 copay per visit for Medicare-covered intensive cardiac rehabilitation services. Prior authorization is required.	You pay a $10 copay per visit for Medicare-covered cardiac rehabilitation services or intensive cardiac rehabilitation services. Prior authorization is required.
Dental services	You pay a $25 copay per visit for Medicare-covered dental services. Prior authorization is required for Medicare-covered dental services.	You pay a $40 copay per office visit for Medicare-covered dental services. Services at other locations during Medicare-covered stays are included in the cost share for those services. Prior authorization is required.

Cost	2017 (this year)	2018 (next year)
	There is no coinsurance, copayment, or deductible for preventive dental services.	There is no coinsurance, copayment, or deductible for preventive dental services.
Diabetes self-management training, diabetic services and supplies	There is no coinsurance, copayment, or deductible for preferred brand Medicare-covered diabetes monitoring supplies. You pay 20% of the total cost for non-preferred brand Medicare-covered diabetes monitoring supplies. The Drug List will indicate preferred status.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes monitoring supplies. Prior authorization is required.
	You pay 20% of the total cost for Medicare-covered therapeutic shoes or inserts.	There is no coinsurance, copayment, or deductible for Medicare-covered therapeutic shoes or inserts. Prior authorization is required.
	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.	There is no coinsurance, copayment, or deductible for diabetes self-management training. Prior authorization is <u>not</u> required.
Emergency care	You pay a $75 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	You pay a $75 copay per visit for all Medicare-covered emergency care services received during visit. If you are admitted to the hospital as inpatient or to outpatient observation within 24 hours for the same condition, you do not have to pay the emergency care copay. If you have outpatient surgical

Cost	2017 (this year)	2018 (next year)
	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.	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, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Hearing services	There is no coinsurance, copayment, or deductible for Medicare-covered PCP diagnostic hearing and balance evaluations. You pay a $25 copay per visit for specialist exams to diagnose and treat hearing and balance issues. Prior authorization is required for specialist exams.	There is no coinsurance, copayment, or deductible for Medicare-covered PCP diagnostic hearing and balance evaluations. You pay a $40 copay per visit for specialist exams to diagnose and treat hearing and balance issues. Prior authorization is required for specialist exams.
Inpatient hospital care	For Medicare-covered hospital stays at an in-network hospital: • You pay a $250 copay per day for days 1 through 6. • There is no coinsurance, copayment, or deductible for days 7 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	For Medicare-covered hospital stays at an in-network hospital: • You pay a $250 copay per day for days 1 through 5. • There is no coinsurance, copayment, or deductible for days 6 through 90. • There is no coinsurance, copayment, or deductible for days 91 through 190. Hospital copays apply on the date of admission. Note: If you are admitted to the hospital in 2017 and are not discharged until sometime in 2018,

Cost	2017 (this year)	2018 (next year)
	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.	the 2017 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility. 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.
Inpatient mental health care	For Medicare-covered hospital stays in a network hospital: • You pay a $250 copay per day for days 1 through 6. • There is no coinsurance, copayment, or deductible for days 7 through 90. 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.	For each Medicare-covered hospital stays in a network hospital: • You pay a $275 copay per day for days 1 through 6. • There is no coinsurance, copayment, or deductible for days 7 through 90. 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 Diabetes Prevention Program (MDPP)	Not covered.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Prior authorization is required.

Cost	2017 (this year)	2018 (next year)
Medicare Part B prescription drugs	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.	You pay 20% of the total cost for Medicare Part B covered drugs. Prior authorization is required.
Outpatient diagnostic tests and therapeutic services and supplies	You pay 20% of the total cost for Medicare-covered: • Lab services • Diagnostic procedures and tests • Outpatient X-rays	There is no coinsurance, copayment, or deductible for Medicare-covered x-rays, laboratory tests, outpatient diagnostic tests (such as, ultrasounds, electrocardiograms, electroencephalograms).
	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 coinsurance.	There is no coinsurance, copayment, or deductible for Medicare-covered surgical supplies, devices used to reduce fractures and dislocations, or blood.
	There is no coinsurance, copayment, or deductible for Medicare-covered surgical supplies, devices used to reduce fractures and dislocations, or blood.	There is no coinsurance, copayment, or deductible for Medicare-covered sleep studies in your home. You pay a $100 copay per visit for Medicare-covered sleep studies in an outpatient facility setting. Prior authorization is required.
	You pay 20% of the total cost for Medicare-covered: • Therapeutic radiology services	You pay a $50 copay per visit for Medicare-covered therapeutic radiology services. If these services are performed during a physician's office visit you do not have to pay the therapeutic radiology copay. Prior authorization is required.
	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	

Cost	2017 (this year)	2018 (next year)
	supplies coinsurance. Prior authorization is required for therapeutic radiology services and diagnostic radiology services (except for emergency care).	
	You pay 20% of the total cost for Medicare-covered: • Diagnostic radiology services (such as MRIs, CT scans) Prior authorization is required for therapeutic radiology services and diagnostic radiology services (except for emergency care).	You pay a $150 copay per visit for other Medicare-covered outpatient diagnostic tests, including but not limited to MRI, CT, PET, and diagnostic colonoscopy. Prior authorization is required.
Outpatient hospital services	You pay a $250 copay per visit for Medicare-covered services in an outpatient facility. 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).	You pay a $75 copay per visit for all Medicare-covered emergency care services received during visit. If you are admitted to the hospital as inpatient or to outpatient observation 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, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Cost	2017 (this year)	2018 (next year)
		You pay a copay of $300 per visit for Medicare-covered observation services. If you are admitted to the inpatient acute level of care from observation, you do not have to pay the outpatient hospital services copay. You pay a $320 copay per visit for Medicare-covered outpatient surgery services. 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. Prior authorization is required. There is no coinsurance, copayment, or deductible for Medicare-covered laboratory, x-rays, medical supplies, and certain screenings and preventive services. You pay 20% of the total cost for the drug and the administration of drugs and biologicals that you can't give yourself. Prior authorization is required. You pay a $55 copay per day for Medicare-covered partial hospitalization program services. Prior authorization is required.
Outpatient mental health care	You pay a $10 copay per visit for Medicare-covered individual therapy sessions.	Individual and/or group therapy sessions provided by a state-licensed psychiatrist or doctor. Medication management and therapy services

Cost	2017 (this year)	2018 (next year)
	You pay a $10 copay per visit for Medicare-covered group therapy sessions.	provided by a state-licensed psychiatrist. You pay a $25 copay per Medicare-covered session. Individual and/or group therapy sessions provided by a state-licensed clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. There is no coinsurance, copayment, or deductible for Medicare-covered sessions.
Outpatient rehabilitation services	You pay a $25 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy. Prior authorization required at least two (2) business days prior to services being rendered. 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.	You pay a $20 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy in an outpatient setting. Prior authorization required at least two (2) business days prior to services being rendered. There is no coinsurance, copayment, or deductible for Medicare-covered services in your home. Prior authorization required at least two (2) business days prior to services being rendered.
Outpatient substance abuse services	You pay a $10 copay per visit for Medicare-covered individual therapy sessions. You pay a $10 copay per visit for Medicare-covered group therapy	Individual and/or group therapy sessions provided by a state-licensed psychiatrist or doctor. Medication management and therapy services provided by a state-licensed psychiatrist.

Cost	2017 (this year)	2018 (next year)
	sessions.	You pay a $25 copay per Medicare-covered session. Individual and/or group therapy sessions provided by a state-licensed clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. There is no coinsurance, copayment, or deductible for Medicare-covered sessions.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $250 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $250 copay per visit for Medicare-covered services in an outpatient facility. 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.	You pay a $250 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $320 copay per visit for Medicare-covered services in an outpatient surgery department. 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.
Over-the-counter items	Not covered.	You are eligible for a $50 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order service. One order in each three month-period. The unused balance does not carry over to the next three months. Prices include shipping, handling, and sales tax. Items may

Cost	2017 (this year)	2018 (next year)
		be purchased for the member only. You pay the prices listed in the catalog. See our website, www.GlobalHealth.com/medicare for the catalog and order form.
Partial hospitalization services	You pay a $25 copay per day for Medicare-covered partial hospitalization program services. Prior authorization is required.	You pay a $55 copay per day for Medicare-covered partial hospitalization program services. Prior authorization is required.
Physician/ Practitioner services, including doctor's office visits	There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services. You pay the regular office visit copay to see a physician assistant, nurse practitioner, or other provider.	There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services. There is no coinsurance, copayment, or deductible to see a physician assistant, nurse practitioner, or other provider in a PCP's office.
	You pay a $25 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. Prior authorization is required for specialist visits except OB/GYN office visits.	You pay a $40 copay per office or telehealth visit for Medicare-covered specialist services. You pay a $40 copay per office visit to see a physician assistant, nurse practitioner, or other provider in a specialist's office. Visits at other locations during Medicare-covered stays are included in the cost-sharing for those services. Prior authorization is required for specialist visits except for OB/GYN office visits.
	See "Dental services" for non-routine dental care cost-sharing information.	You pay a $40 copay per office visit for Medicare-covered dental services. Services at other locations during Medicare-covered stays are included

Cost	2017 (this year)	2018 (next year)
		in the cost share for those services. Prior authorization is required for services performed in an office setting.
Podiatry services	You pay a $25 copay per visit for Medicare-covered podiatry services. Prior authorization is required.	You pay a $40 copay per visit for Medicare-covered podiatry services. Prior authorization is required.
Pulmonary rehabilitation services	You pay a $25 copay per visit for Medicare-covered pulmonary rehabilitation services. Prior authorization is required.	You pay a $30 copay per office visit for Medicare-covered pulmonary rehabilitation services. Prior authorization is required.
Services to treat kidney disease and conditions	There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services including self-dialysis training. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services including self-dialysis training. Prior authorization is required.
	You pay 20% of the total cost for Medicare-covered renal dialysis. Prior authorization is required.	You pay a $30 copay for each Medicare-covered renal dialysis treatment in an outpatient facility. Prior authorization is required.
		No additional charge for dialysis in during a Medicare-covered inpatient hospital admission. Refer to "Inpatient hospital care" in the Medical Benefits Chart of the Evidence of Coverage for cost share. Prior authorization is required.
	You pay the home health agency care cost share for home support services. You pay the home health agency care cost share for home dialysis equipment if provided by a home health agency. Otherwise, you pay	There is no coinsurance, copayment, or deductible for Medicare-covered self-dialysis or home support services. Certain drugs for dialysis are covered under Part B drug benefit.

Cost	2017 (this year)	2018 (next year)
	the durable medical equipment cost share. Prior authorization is required.	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. Prior authorization is required.
Skilled nursing facility (SNF) care	For Medicare-covered skilled nursing facility stays: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a $105 copay per day for days 21 through 100. Prior authorization is required.	For Medicare-covered skilled nursing facility stays per benefit period: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a $160 copay per day for days 21 through 100. Prior authorization is required.
Urgently needed services	You pay a $25 copay per visit for Medicare-covered urgently needed services.	You pay a $10 copay per visit for Medicare-covered urgently needed services.
Vision care	There is no coinsurance, copayment, or deductible for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including glaucoma screening. Prior authorization is required for glaucoma screening.	There is no coinsurance, copayment, or deductible for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. There is no coinsurance, copayment, or deductible for Medicare-covered screenings. Prior authorization is not required.
	There is no coinsurance, copayment, or deductible for one supplemental routine eye exam per year.	There is no coinsurance, copayment, or deductible for one supplemental exam.
	You pay 20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.	There is no coinsurance, copayment, or deductible for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.

Cost	2017 (this year)	2018 (next year)
	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.	Choice of one supplemental pair of eyeglasses (frames and lenses) or one set of contact lenses per year. You pay a $50 copay. We will only pay up to a total of $200 for supplemental eye wear per year. If the eye wear you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance.
Wigs for Hair Loss Related to Chemotherapy	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.	You pay a $15 copay 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 Administrative Changes

The items below have a change in prior authorization requirements.

Cost	2017 (this year)	2018 (next year)
Ambulance services	Prior authorization is not required.	Prior authorization is required for non-emergency transportation.
Colorectal cancer screening	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. Prior authorization is required.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. Prior authorization is required for FIT-DNA based tests, flexible sigmoidoscopy and screening

Cost	2017 (this year)	2018 (next year)
		colonoscopy.
Screening for lung cancer with low dose computed tomography (LDCT)	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. Prior authorization is not required.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. Prior authorization is required.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Generations Value (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 2018.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Review and Compare Your Coverage Options." **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 Value (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Value (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 7.1 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 4 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, 2018.

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 8, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 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 6 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 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP). Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call HIV Drug Assistance Program (HDAP) at (405) 271-4636.

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 7 Questions?

Section 7.1 – Getting Help from Generations Value (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 am to 8:00 pm, seven days a week, from October 1 – February 14, and 8:00 am to 8:00 pm Monday – Friday from February 15 – September 30. Calls to these numbers are free.

Read your 2018 *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 2018. For details, look in the 2018 *Evidence of Coverage* for Generations Value (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 Directory*).

Section 7.2 – 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 (https://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 https://www.medicare.gov and click on “Find health & drug plans.”)

Read Medicare & You 2018

You can read *Medicare & You 2018* 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 (https://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)
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www.GlobalHealth.com/medicare