GlobalHealth

Annual Notice of Changes

January 1 – December 31, 2020

Generations Classic (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 - March 31)
8 a.m. to 8 p.m., Monday - Friday
(April 1 - September 30)
www.GlobalHealth.com/medicare-advantage

H3706_CLASSICANOC_2020_M File & Use 08/30/2019

Generations Classic (HMO) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2020

You are currently enrolled as a member of Generations Classic (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 Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, 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 Classic (HMO), you don't need to do anything. You will stay in Generations Classic (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, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Generations Classic (HMO).
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020.**

Additional Resources

- Please contact our Customer Care number at (405) 280-5555 (local) or 1-844-280-5555 (toll-free) for additional information. (TTY users should call 711.) Hours are 8:00 am to 8:00 pm, seven days a week, from October 1 – March 31, and 8:00 am to 8:00 pm Monday – Friday from April 1 – September 30.
- This information is also available in large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** 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 Classic (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 Classic (HMO).

H3706_CLASSICANOC_2020_M File & Use 08/30/2019

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Generations Classic (HMO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.GlobalHealth.com/medicare-advantage. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $40 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 $365 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.	You pay a $395 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.

Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. • Drug Tier 6: $10 Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. • Drug Tier 6: $5 Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. • Drug Tier 6: $10 Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage continued	• Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. • Drug Tier 6: $5 Standard 90-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost • Drug Tier 6: $30 Preferred 90-day Retail Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $126 • Drug Tier 4: 40% of the total cost • Drug Tier 6: $0 Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost • Drug Tier 6: $30 Preferred 90-day Mail-order Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $126 • Drug Tier 4: 40% of the total cost	• Drug Tier 5: 33% of the total cost. Standard 90-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost Preferred 90-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $84 • Drug Tier 4: 40% of the total cost Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost Preferred 90-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $84 • Drug Tier 4: 40% of the total cost

Annual Notice of Changes for 2020
Table of Contents

Summary of Important Costs for 2020 1

SECTION 1 Changes to Benefits and Costs for Next Year 5

Section 1.1 – Changes to the Monthly Premium 5

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount 5

Section 1.3 – Changes to the Provider Network 5

Section 1.4 – Changes to the Pharmacy Network 6

Section 1.5 – Changes to Benefits and Costs for Medical Services 6

Section 1.6 – Changes to Part D Prescription Drug Coverage 13

SECTION 2 Administrative Changes 17

SECTION 3 Deciding Which Plan to Choose 17

Section 3.1 – If you want to stay in Generations Classic (HMO) 17

Section 3.2 – If you want to change plans 17

SECTION 4 Deadline for Changing Plans 18

SECTION 5 Programs That Offer Free Counseling about Medicare 19

SECTION 6 Programs That Help Pay for Prescription Drugs 19

SECTION 7 Questions? 20

Section 7.1 – Getting Help from Generations Classic (HMO) 20

Section 7.2 – Getting Help from Medicare 20

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

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

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	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 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-advantage. You may also call Customer Care for updated provider information or to ask us to mail you a Provider Directory.

Please review the 2020 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, we must 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 the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.GlobalHealth.com/medicare-advantage. You may also call Customer Care for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Abdominal aortic aneurysm screening	Prior authorization is required for abdominal aortic aneurysm screening.	No prior authorization is required.
Ambulance services	You pay a $100 copay for Medicare-covered ambulance services per one-way trip. If you are admitted to the hospital, you do not have to pay the ambulance services copay. Prior authorization is required for non-emergency transportation.	You pay a $250 copay for Medicare-covered ambulance services per one-way trip. If you are admitted to the hospital, you do not have to pay the ambulance services copay. Prior authorization is required for non-emergency transportation.
Colorectal cancer screening	Prior authorization is required for flexible sigmoidoscopy and screening colonoscopy.	No prior authorization is required.

Dental services	• Preventive dental services
	  ○ Cleaning (for up to 2 every year)
	  ○ Dental x-ray(s) (for up to 2 every year)
	  ○ Oral exam (for up to 2 every year)
	• Prosthodontic dental services
	  ○ Dentures
	There is no coinsurance, copayment, or deductible for preventive dental services.
	There is no coinsurance, copayment, or deductible for dentures.
	We will only pay up to a total of $750 for dentures per year. If the dentures you purchase cost more than this allowed
		• Preventive dental services
		  ○ Cleaning (for up to 2 every year)
		  ○ Dental x-ray(s) (for up to 2 every year)
		  ○ Oral exam (for up to 2 every year)
		• Non-preventive dental services
		  ○ Non-routine services
		  ○ Diagnostic services
		  ○ Restorative services
		  ○ Endodontics
		  ○ Periodontics
		  ○ Extractions
		  ○ Prosthodontics (dentures)
		There is no coinsurance, copayment, or deductible for these dental services.

Cost	2019 (this year)	2020 (next year)
Dental services continued	amount, you pay the amount that exceeds this allowance.	We will only pay up to a total of $1,000 for these dental services per year. You pay the amount that exceeds this allowance.
Emergency care	You pay a $100 copay per visit for all Medicare-covered emergency care services received during the visit.	You pay a $120 copay per visit for all Medicare-covered emergency care services received during the visit.
Health and wellness education programs	Not covered	You pay $0 for an annual Silver&Fit® membership fee.
Hearing services	Prior authorization is required.	No prior authorization is required.
Hearing routine exam	Not covered	There is no coinsurance, copayment, or deductible for one routine hearing exam.
Hearing aids	Not covered	There is no coinsurance, copayment, or deductible for hearing aids and services. We will only pay up to a total of $500 for these services per year. You pay the amount that exceeds this allowance.
Help with certain chronic conditions	If you have been diagnosed by a plan provider and meet certain criteria for the following: • Diabetes • Heart failure • Chronic obstructive pulmonary disease • Coronary artery disease	If you have been diagnosed by a plan provider and meet certain criteria for the following: • Diabetes • Heart failure • Chronic obstructive pulmonary disease (COPD)

Cost	2019 (this year)	2020 (next year)
Help with certain chronic conditions continued	• Hypertension You are eligible for 6 rides to and from doctor appointments. Prior authorization is required.	• Coronary artery disease (CAD) • Hypertension • Blindness You are eligible for 6 roundtrips to and from doctor appointments. You are eligible for 10 meals following inpatient discharge, up to 4 times per year. Prior authorization is required.
Inpatient hospital care	For Medicare-covered hospital stays at an in-network hospital: • You pay a $365 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.	For Medicare-covered hospital stays at an in-network hospital: • You pay a $395 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.
Medical nutrition therapy	Prior authorization is required for medical nutrition therapy.	No prior authorization is required.
Opioid Treatment Program	Not covered.	There is no coinsurance, copayment, or deductible for Medicare-covered services. Prior authorization is required.
Outpatient diagnostic tests and therapeutic services and supplies • Other outpatient diagnostic tests,	You pay a $150 copay per visit for Medicare-covered services. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered ultrasounds. You pay a $180 copay per visit for other Medicare-

Cost	2019 (this year)	2020 (next year)
Outpatient diagnostic tests and therapeutic services and supplies continued including but not limited to: o Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET)		covered services in a PCP or specialist office setting, urgent care facility, or a preferred (non-hospital based) radiological facility. Prior authorization is required except in PCP office. You pay a $250 copay per visit for Medicare-covered services in a non-preferred (hospital based) radiological facility. Prior authorization is required.
Outpatient hospital services • Hyperbaric oxygen therapy	You pay a $320 copay per visit for Medicare-covered services.	You pay a $40 copay per visit for Medicare-covered care. Prior authorization is required.
Outpatient hospital services • Wound care	You pay a $25 copay per visit for Medicare-covered services.	You pay a $15 copay per visit for Medicare-covered care. Prior authorization is required.
Over-the-counter items	You are eligible for a $30 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order service.	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.
Physician/Practitioner services, including doctor's office visits	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	<u>PCP office visits:</u> There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services, except specialized diagnostic tests and Part B drugs, during an office or telehealth visit.

Cost	2019 (this year)	2020 (next year)
Physician/Practitioner services, including doctor's office visits continued	practitioner, or other provider in your PCP's office	There is no coinsurance, copayment, or deductible to see a physician assistant, nurse practitioner, or other provider in your PCP's office. Visits at other locations during Medicare-covered stays are included in the cost-sharing for those services. <u>Specialized outpatient diagnostic tests:</u> You pay a separate $180 copay for outpatient diagnostic tests, including but not limited to magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET). <u>Part B drugs:</u> You pay 20% of the total cost for Medicare Part B covered drugs. Prior authorization is required.
Physician/Practitioner services, including doctor's office visits **Physician/Practitioner services, including**	You pay a $40 copay per office visit for Medicare-covered specialist services during an office or telehealth visit. You pay a $40 copay per office or telehealth 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	<u>Specialist office visits:</u> You pay a $40 copay per office visit for Medicare-covered specialist services during an office or telehealth visit. You pay a $40 copay per office or telehealth 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

Cost	2019 (this year)	2020 (next year)
doctor's office visits continued	included in the cost-sharing for those services. Prior authorization is required except for OB/GYN office visits.	included in the cost-sharing for those services. No prior authorization is required. Specialized outpatient diagnostic tests: You pay a separate $180 copay for outpatient diagnostic tests, including but not limited to magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET). Prior authorization is required. Part B drugs: You pay 20% of the total cost for Medicare Part B covered drugs. Prior authorization is required.
Podiatry services	You pay a $20 copay per office visit for Medicare-covered podiatry services. Prior authorization is required.	You pay a $30 copay per office visit for Medicare-covered podiatry services. No prior authorization is required.
Screening for lung cancer with low dose computed tomography (LDCT)	Prior authorization is required for LCDT.	No prior authorization is required.
Skilled nursing facility (SNF) care **Skilled nursing facility (SNF) care continued**	For Medicare-covered skilled nursing facility stays per benefit period: • There is no coinsurance, copayment, or deductible for days 1 through 20.	For Medicare-covered skilled nursing facility stays per benefit period: • There is no coinsurance, copayment, or deductible for days 1 through 20.

Cost	2019 (this year)	2020 (next year)
	• You pay a $160 copay per day for days 21 through 100.	• You pay a $178 copay per day for days 21 through 100.
Urgently needed services	You pay a $35 copay per visit for Medicare-covered urgently needed services.	Urgent care visits: You pay a $30 copay per visit for Medicare-covered urgently needed services, except specialized diagnostic tests, during the visit. Specialized diagnostic tests: You pay a $180 copay for outpatient diagnostic tests, including but not limited to magnetic resonance imaging (MRI), computer tomography (CT), and positron emission tomography (PET).
Wigs for Hair Loss Related to Chemotherapy	You pay a $15 copay. 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.	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 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

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

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

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

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions do not continue from year to year. You will need to submit a new request for formulary exceptions each year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2019, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are in Section 7.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.GlobalHealth.com/medicare-advantage. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Cost	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription.

Cost	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage continued tier, look them up on the Drug List.	*Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-preferred Drugs):** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. _____ Once your total drug costs have reached $3,820 you	*Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-preferred Drugs):** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost. _____ Once your total drug costs have reached $4,020 you will move to the next stage (the Coverage Gap Stage).

Cost	2019 (this year)	2020 (next year)
	will move to the next stage (the Coverage Gap Stage).	

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Cost	2019 (this year)	2020 (next year)
Formulary	6 Tier Generic Strategy Standard	5 Tier Generic Strategy Standard

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Generations Classic (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 2020.

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 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (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 "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Generations Classic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Classic (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, 2020.

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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, 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.

Senior Health Insurance Counseling Program 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 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 at 1-800-763-2828. You can learn more about Senior Health Insurance Counseling Program 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).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HIV Drug Assistance Program (HDAP) at (405) 271-4636.

SECTION 7 Questions?

Section 7.1 – Getting Help from Generations Classic (HMO)

Questions? We're here to help. Please call Customer Care at (405) 280-5555 (local) or 1-844-280-5555 (toll-free). (TTY only, call 711.) We are available for phone calls 8:00 a.m. to 8:00 p.m., seven days a week, from October 1 – March 31, and 8:00 a.m. to 8:00 p.m. Monday – Friday from April 1 – September 30. Calls to these numbers are free.

Read your 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Generations Classic (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 located on our website at www.GlobalHealth.com/medicare-advantage. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

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 2020*

You can read the *Medicare & You 2020* 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 - March 31)
8 a.m. to 8 p.m., Monday - Friday (April 1 - September 30)
www.GlobalHealth.com/medicare-advantage