GlobalHealth

Annual Notice of Changes

January 1 – December 31, 2020

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

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Generations Value (HMO) *offered by* GlobalHealth, Inc.

Annual Notice of Changes for 2020

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, 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.

OMB Approval 0938-1051 (Expires: December 31, 2021)

- Look in Section 2.2 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, 2019**

   - If you don't join another plan by **December 7, 2019**, you will stay in Generations Value (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 1-844-280-5555 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 Value (HMO)

- GlobalHealth, Inc. is an HMO with a Medicare contract. Enrollment in GlobalHealth, Inc. 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 2020

The table below compares the 2019 costs and 2020 costs for Generations Value (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	$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.)	$3,000	$3,000
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 $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.	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	2019 (this year)	2020 (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	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.	$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-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 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 for abdominal aortic aneurysm screening.
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 $150 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.

Cost	2019 (this year)	2020 (next year)
Colorectal cancer screening	Prior authorization is required for flexible sigmoidoscopy and screening colonoscopy.	No prior authorization is required for abdominal aortic aneurysm screening.

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)
	There is no coinsurance, copayment, or deductible for preventive dental.
		• 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.
		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.

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.

Cost	2019 (this year)	2020 (next year)
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 • Hypertension You are eligible for 6 rides to and from doctor appointments.	If you have been diagnosed by a plan provider and meet certain criteria for the following: • Diabetes • Heart failure • Chronic obstructive pulmonary disease (COPD) • 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.
Medical nutrition therapy	Prior authorization is required for medical nutrition therapy.	No prior authorization is required for medical nutrition therapy.
Opioid Treatment Program	Not covered.	There is no coinsurance, copayment, or deductible for Medicare-covered services. Prior authorization is required.

Cost	2019 (this year)	2020 (next year)
Outpatient diagnostic tests and therapeutic services and supplies • Other outpatient diagnostic tests, including but not limited to: o Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET)	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-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.
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 practitioner, or other provider in your PCP's office	<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. There is no coinsurance, copayment, or deductible to see

Cost	2019 (this year)	2020 (next year)
Physician/Practitioner services, including doctor's office visits continued		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.
Physician/Practitioner services, including doctor's office visits	You pay a $40 copay per office or telehealth visit for Medicare-covered specialist services. 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. Prior authorization is required except for OB/GYN office visits.	<u>Specialist office visits:</u> You pay a $40 copay per office or telehealth visit for Medicare-covered specialist services, except specialized diagnostic tests and Part B drugs, 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 location during Medicare-covered stays are included in the cost-sharing for those services.

Cost	2019 (this year)	2020 (next year)
Physician/Practitioner services, including doctor's office visits continued		No prior authorization is required. <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). Prior authorization is required. <u>Part B drugs:</u> You pay 20% of the total cost for Medicare Part B covered drugs. Prior authorization is required.
Podiatry services	You pay a $40 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 for LCDT.
Skilled nursing facility (SNF) care	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)
Skilled nursing facility (SNF) care continued	• 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 $10 copay per visit for Medicare-covered urgently needed services.	Urgent care visits: You pay a $15 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 2 Deciding Which Plan to Choose

Section 2.1 – 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 2020.

Section 2.2 – 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, there may be 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 (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 prescription drug 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 3 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 8, 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 8, Section 2.2 of the *Evidence of Coverage*.

SECTION 4 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 5 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 6 Questions?

Section 6.1 – 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 – March 31, and 8:00 am to 8:00 pm 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 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 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).

Section 6.2 – 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 *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.

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