



GlobalHealth
Medicare Advantage Plans

2022 SUMMARY OF BENEFITS

January 1 – December 31, 2022
Texas



GlobalHealth Medicare Advantage Plan Options:

H6062-001 Global Classic (HMO)

H6062-003 Global Classic (HMO)

1-844-200-8167 (TTY: 711)

8 a.m. to 8 p.m. 7 days a week (October 1 - March 31)

Monday - Friday (April 1 - September 30)

www.GlobalHealth.com

H6062_SBCLASSIC_2022_M

GlobalHealth is an HMO/HMO C-SNP plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please see the “Evidence of Coverage.” The Evidence of Coverage can be found online at www.GlobalHealth.com, or you can request a copy from Customer Care at 1-844-200-8167 (TTY: 711).

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

2022 Service Area

Collin

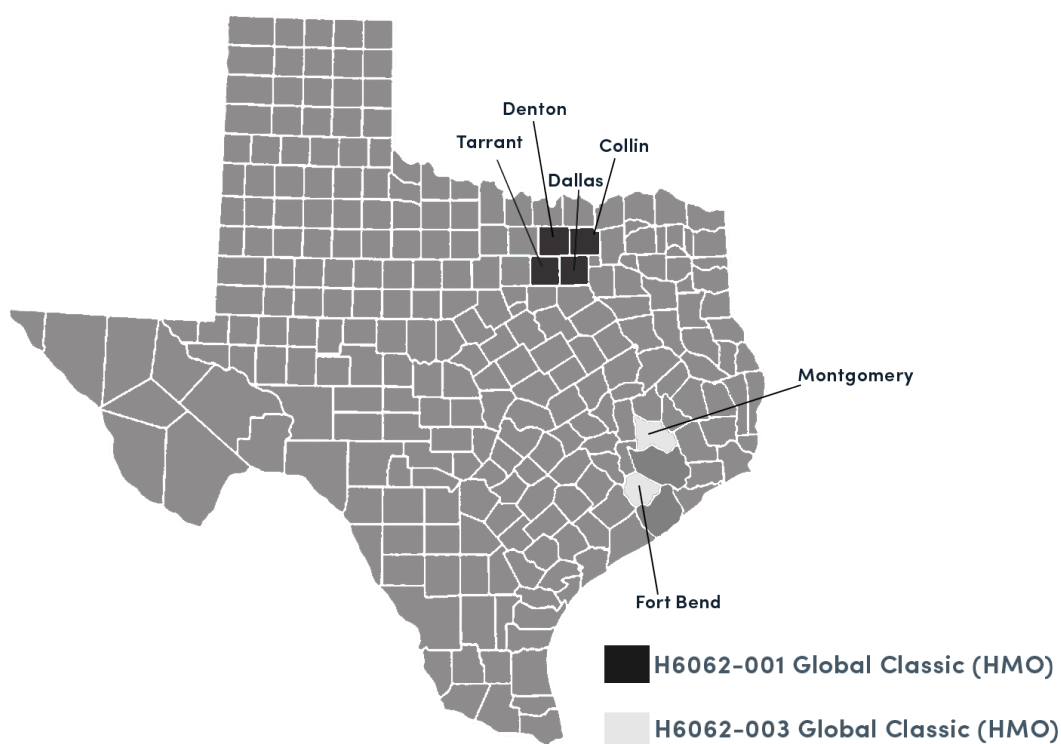
Dallas

Denton

Fort Bend

Montgomery

Tarrant



Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “**Medicare & You**” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week.

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

For more information, please call us at 1-844-200-8167 (TTY: 711), or visit us at www.GlobalHealth.com.



2022

GlobalHealth Medicare Advantage Plan Summary of Benefits

GlobalHealth Medicare Advantage Plans

Summary of Benefits

January 1, 2022 – December 31, 2022

Plans may offer supplemental benefits in addition to Part C benefits.

	H6062-001 Global Classic (HMO)	H6062-003 Global Classic (HMO)
Monthly Plan Premium (You must continue to pay your Part B premium)	\$0	\$0
Deductible	\$0	\$0
Maximum Out-of-Pocket (MOOP) Annually (Does not include supplemental benefits or prescription drugs)	\$3,400	\$4,500
INPATIENT CARE		
Inpatient Hospital Coverage ^{1,2}	\$250 copay per day (Days 1-7); \$0 copay per day (Days 8-190)	\$315 copay per day (Days 1-7); \$0 copay per day (Days 8-190)
Inpatient Mental Health Care ^{1,2}	\$250 copay per day (Days 1-7); \$0 copay per day (Days 8-90)	\$265 copay per day (Days 1-7); \$0 copay per day (Days 8-90)
Skilled Nursing Facility (SNF) ^{1,2}	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100)	\$0 copay per day (Days 1-20); \$184 copay per day (Days 21-100)
OUTPATIENT CARE		
Doctor Visits	• \$0 copay per visit for PCP • \$30 copay per visit for specialists ^{1,2}	• \$0 copay per visit for PCP • \$30 copay per visit for specialists ^{1,2}
Chiropractic Services	\$20 copay per visit	\$20 copay per visit
Podiatry Services ^{1,2}	\$30 copay per visit	\$30 copay per visit
Outpatient Mental Health Visit ^{1,2}	\$30 copay per visit	\$30 copay per visit

¹ Prior Authorization Required

² Referral Required

	H6062-001 Global Classic (HMO)	H6062-003 Global Classic (HMO)
Ambulatory Surgery Center ^{1,2}	\$200 copay per visit	\$265 copay per visit
Outpatient Hospital Observation Services ^{1,2}	\$250 copay per visit	\$315 copay per visit
Outpatient Hospital Surgery ^{1,2}	\$250 copay per visit	\$315 copay per visit
Emergency Care	\$120 copay per visit; waived if admitted to acute care	\$90 copay per visit; waived if admitted to acute care
Worldwide Emergency Care (Does not accumulate to MOOP)	<ul style="list-style-type: none"> • \$120 copay per visit • Limited to \$50,000 benefit combined with urgent care 	<ul style="list-style-type: none"> • \$90 copay per visit • Limited to \$50,000 benefit combined with urgent care
Urgently Needed Services	\$65 copay per visit	\$65 copay per visit
Worldwide Urgent Care (Does not accumulate to MOOP)	<ul style="list-style-type: none"> • \$120 copay per visit • Limited to \$50,000 benefit combined with emergency care 	<ul style="list-style-type: none"> • \$90 copay per visit • Limited to \$50,000 benefit combined with emergency care
Outpatient Labs, X-Rays, Etc.	\$0 - labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	\$0 - labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics
Outpatient ^{1,2} Therapeutic Radiology	You pay 20% of the cost per visit	You pay 20% of the cost per visit
Outpatient ^{1,2} Diagnostic Radiology (MRI, etc.)	<ul style="list-style-type: none"> • \$175 copay per visit in PCP, specialist, urgent care, freestanding radiological facility • \$250 outpatient hospital 	<ul style="list-style-type: none"> • \$180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility • \$315 outpatient hospital
Outpatient Rehabilitation Services ^{1,2} (Physical, occupational, and/or speech therapy)	\$30 copay per visit	\$30 copay per visit
Acupuncture ^{1,2}	\$30 copay per visit	\$30 copay per visit
Ambulance (One-way trip)	<ul style="list-style-type: none"> • \$225 per occurrence for ground • You pay 20% of the cost per occurrence for air 	<ul style="list-style-type: none"> • \$225 per occurrence for ground • You pay 20% of the cost per occurrence for air
Home Health Services ^{1,2}	\$0	\$0
PREVENTIVE CARE		
Preventive Services	\$0 for Medicare-covered preventive services	\$0 for Medicare-covered preventive services

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	H6062-001 Global Classic (HMO)	H6062-003 Global Classic (HMO)
PART B DRUGS		
Medicare Part B Drugs ^{1,2} (Includes chemotherapy)	You pay 20% of the cost	You pay 20% of the cost
OUTPATIENT MEDICAL SUPPLIES		
Durable Medical Equipment ¹ (e.g., Continuous glucose monitors (CGM), wheelchairs, oxygen)	You pay 20% of the cost	You pay 20% of the cost
Standard Diabetic Testing Supplies ¹	You pay 20% of the cost	You pay 20% of the cost
Prosthetics and Related Supplies ¹ (e.g., Braces, artificial limbs)	You pay 20% of the cost	You pay 20% of the cost
SUPPLEMENTAL BENEFITS		
Hearing Services	<ul style="list-style-type: none"> • \$0 routine hearing exam limited to one per year • \$0 routine hearing aid evaluation limited to one per year • Our plan pays up to a total of \$500 for hearing aids per year 	<ul style="list-style-type: none"> • \$0 routine hearing exam limited to one per year • \$0 routine hearing aid evaluation limited to one per year • Our plan pays up to a total of \$500 for hearing aids per year
Dental Services	<ul style="list-style-type: none"> • \$0 preventive services - oral exams, x-rays, cleanings, and fluoride treatments • Our plan pays a total of \$1,000 for comprehensive dental services per year • You pay 30% of the cost for some comprehensive services 	<ul style="list-style-type: none"> • \$0 preventive services - oral exams, x-rays, cleanings, and fluoride treatments
Vision Services	<ul style="list-style-type: none"> • \$0 routine eye exam limited to 1 per year • Our plan pays up to a total of \$100 for all supplemental eyewear per year 	<ul style="list-style-type: none"> • \$0 routine eye exam limited to 1 per year • Our plan pays up to a total of \$100 for all supplemental eyewear per year
Transportation ¹ (To and from plan-approved locations)	<ul style="list-style-type: none"> • \$0 per trip • Limited to 12 one-way trips per year • Limited to 50 miles per one-way trip 	<ul style="list-style-type: none"> • \$0 per trip • Limited to 6 one-way trips per year • Limited to 50 miles per one-way trip
Over-the-Counter Benefit (Includes nicotine replacement therapy)	Plan pays \$50 per quarter	Plan pays \$50 per quarter
Fitness	\$0	\$0
24/7 Nurse Line	\$0	\$0
Post-Discharge Meal Delivery ¹	<ul style="list-style-type: none"> • \$0 per meal • Limited to 10 meals following discharge • Limited to 4 times per year 	<ul style="list-style-type: none"> • \$0 per meal • Limited to 10 meals following discharge • Limited to 4 times per year

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PART D DRUGS		
Phase 1: Deductible	\$0	\$0
Phase 2: Initial Coverage Limit (ICL)	\$4,430	\$4,430
Tier 1: Preferred Generics* (Preferred Retail 30-Day Supply)	\$5 copay per fill	\$5 copay per fill
Tier 2: Generic* (Preferred Retail 30-Day Supply)	\$15 copay per fill	\$15 copay per fill
Tier 3: Preferred Brand* (Preferred Retail 30-Day Supply)	\$42 copay per fill	\$42 copay per fill
Tier 4: Non-Preferred Drug* (Preferred Retail 30-Day Supply)	\$90 copay per fill	\$90 copay per fill
Tier 5: Specialty Tier* (Preferred Retail 30-Day Supply)	You pay 33% of the cost per fill	You pay 33% of the cost per fill
Tier 1: Preferred Retail & Mail Order (100-Day Supply)	\$10 copay per fill	\$10 copay per fill
Tier 2: Preferred Retail & Mail Order (100-Day Supply)	\$30 copay per fill	\$30 copay per fill
Tier 3: Preferred Retail & Mail Order (100-Day Supply)	\$84 copay per fill	\$84 copay per fill
Tier 4: Preferred Retail & Mail Order (100-Day Supply)	\$270 copay per fill	\$270 copay per fill
Phase 3: GAP Coverage Stage ³ (After your prescription costs reach \$4,430)	<p>Generic Drugs:</p> <ul style="list-style-type: none"> GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs or Tier 3 oral antidiabetics. Members pay 25% of the cost for other generic drugs. <p>Brand Name Drugs:</p> <ul style="list-style-type: none"> The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs. 	
Phase 4: Catastrophic Coverage Stage (After your prescriptions reach \$7,050)	You pay the greater 5% of the cost of the drug or \$3.95 for generics/\$9.85 for brand names.	

*Cost-sharing may differ depending on the pharmacy's status (e.g., preferred, non-preferred, mail-order, Long Term Care (LTC) or home infusion) or the supply (e.g., 30 or 100-day supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access the Evidence of Coverage at www.GlobalHealth.com.

³You stay in this stage until your year-to-year "out-of-pocket" (you payments) reach a total of \$7,050. This amount and rules for counting costs toward this amount have been set by Medicare.

PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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[illegible]



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www.GlobalHealth.com/medicare-advantage/member-materials

Provider Directory: www.GlobalHealth.com
Pharmacy Directory: www.GlobalHealth.com

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

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

2022 Service Area

Collin

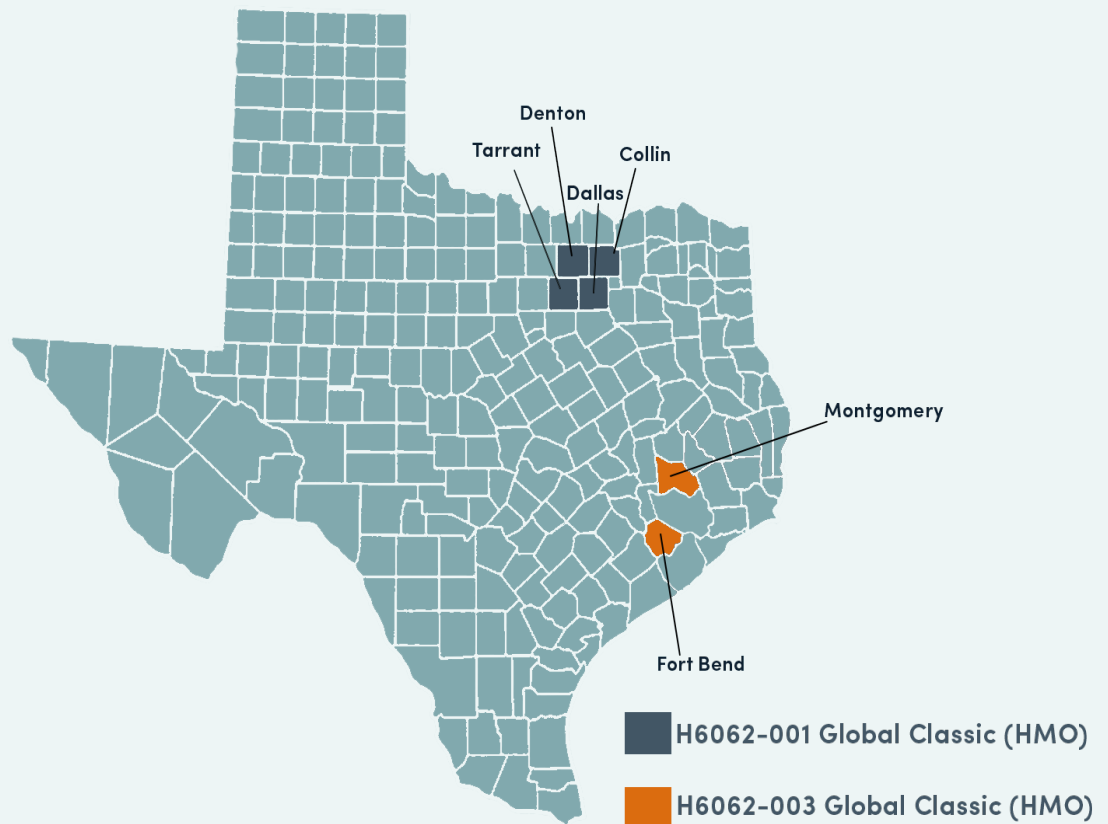
Dallas

Denton

Fort Bend

Montgomery

Tarrant



GlobalHealth

Medicare Advantage Plans

For questions or to enroll:

1-844-200-8167 (TTY: 711)

www.GlobalHealth.com

By calling the listed number you may be speaking with a licensed sales representative.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

GlobalHealth cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. GlobalHealth tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

You must continue to pay your Medicare Part B premium. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.