GlobalHealth
Generations Medicare Advantage Plans

2021 ALL-IN-ONE GUIDE

Generations Medicare Advantage Plan Options:

Generations Value (HMO)

Generations Classic (HMO)

NEW! Generations Classic Choice (HMO-POS)

Generations Select (HMO)

Call Our Medicare Helpline

1-844-322-8322 (TTY: 711)

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Enrolling in a GlobalHealth Generations Medicare Advantage Plan

There are five easy ways to submit your enrollment:

Enroll online:
Go to www.GlobalHealth.com and login to the Agent/Broker portal to access the enrollment platform.

Medicare beneficiaries may also enroll in a GlobalHealth Generations Medicare Advantage Plan through the CMS Online Enrollment Center located at: www.Medicare.gov.

Mail:
Follow these easy steps to enroll in a GlobalHealth Generations Medicare Advantage Plan:

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

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

Enrolling in a GlobalHealth Generations Medicare Advantage Plan

Call us:
To enroll by phone, please call us at 1-844-322-8322 (TTY: 711)*.

Fax:
Fill out the paper enrollment form on the following pages and fax it, along with any other required documentation to:
405-280-5881

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

To avoid delays with your enrollment, please do not submit your enrollment information more than once.

If you need assistance in filling out your enrollment form or have any questions, please call us at 1-844-322-8322 (TTY: 711)*.

FOR AGENT USE ONLY:

Agent Online Enrollment:
You have the option to enroll a member on our website:
https://agents.globalhealth.com/

For more information on enrolling, including a pre-enrollment checklist as well as an enrollment application, please see pages 46-50.

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

Medicare Advantage Plans

About GlobalHealth

- Local, Oklahoma-based health maintenance organization (HMO)
- Available in 51 counties for 2021
- 4 Medicare Advantage plans
- Local Customer Care, Care Management and Pharmacy teams
- Thousands of quality providers, pharmacies and many major hospitals

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

A Medicare Advantage plan is an all-in-one alternative to Original Medicare to enhance your health coverage. Medicare Part C, such as a plan from GlobalHealth, combines Part A and Part B and often Part D prescription drugs. Medicare Part C usually offers more benefits for services such as dental, vision and low to no copays on physician visits. You must have Medicare Part A and B to enroll in a Medicare Advantage plan.

Are you eligible for Generations Medicare Advantage Plans?

- Must be a permanent resident in our service area
- Must have both Medicare Part A and Part B

What Do You Know About Medicare?

The Four Parts of Medicare

PART A

Hospital Insurance

PART B

Medical Insurance

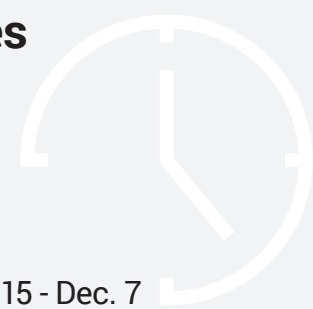
PART C

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

PART D

Prescription Drug Coverage

Medicare Advantage (MA) Enrollment Dates



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

Annual enrollment Oct. 15 - Dec. 7
If you're eligible, you can join, switch or drop an MA plan.

Open enrollment Jan. 1 - Mar. 31
MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare.

Apr. 1 - Oct. 14
No plan changes unless special enrollment period.

What Do You Know About Medicare?

Prescription Drug Coverage

Deductible Stage

You pay the full cost of your drugs until you meet your deductible.*

Example:
Drug = $50
You pay = $50

$50 towards deductible*

***NO deductible on our plans.**

Initial Coverage Stage

The plan pays its share of the cost, and you pay your share (copayment/ coinsurance) until your total drug costs reach $4,130.

Example:
Drug = $50
Plan pays = $40
You pay = $10

$50 towards initial coverage limit

Coverage Gap Stage

You will pay no more than 25% for covered generics or 25% on all other drugs plus a portion of the dispensing fee until you reach $6,550.

Generic Example:
Drug = $50
Plan pays = 75% ($37.50)
You pay = 25% ($12.50)

$12.50 towards coverage gap

Gap Coverage for the following: - All Tier 1 drugs - Tier 3 oral antidiabetics

Catastrophic Coverage Stage

You will pay the greater of 5% of the cost or $3.70 for generics and $9.20 for all other drugs.

Generic Example:
Drug = $50
Plan pays = $46.30
You pay = $3.70

Need Extra Help? *You May Qualify!*

You may be able to get Extra Help with your prescription drug costs.

To find out if you qualify, call:

- GlobalHealth: 1-844-322-8322 (TTY: 711)*
- Medicare: 1-800-MEDICARE (1-800-633-4227], 24 hours a day, 7 days a week (TTY: 1-877-486-2048)
- Social Security Office: 1-800-772-1213, 7:00 AM to 7:00 PM (TTY: 1-800-325-0778)
- State Medicaid (SoonerCare Helpline): 1-800-987-7767

2021 Premium Subsidy Tables for Those Who Qualify for Extra Help

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

	Your Monthly Premium**		
Your Extra Level of Help	**Generations Classic**	**Generations Classic Choice**	**Generations Select**
100%	$0	$0	$0
75%	$0	$2.50	$7.20
50%	$0	$5.00	$14.50
25%	$0	$7.50	$21.70

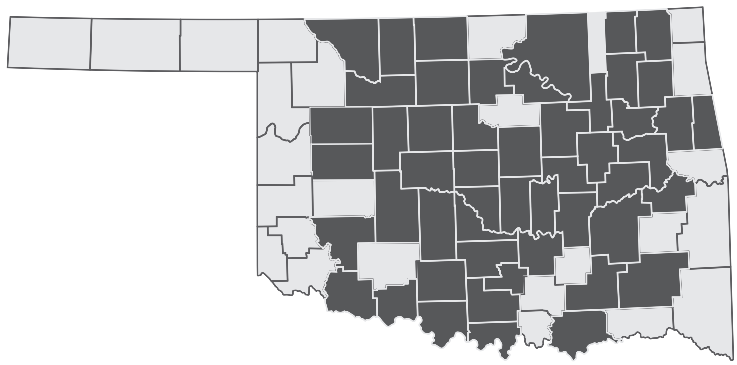
*By calling the listed number you may be speaking with a licensed sales representative.
**This does not include any Medicare Part B premium you may have to pay.

What Do You Know About Medicare?

Key Terms

- **Coinsurance:** An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).
- **Copayment (copay):** An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
- **Cost Share:** Cost-sharing refers to amounts that a member has to pay when services or drugs are received (for example, your copayment or coinsurance).
- **Deductible:** The amount you must pay for healthcare or prescriptions before the plan begins to pay.
- **Drug Formulary:** A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.
- **Health Maintenance Organization – Point of Service (HMO-POS):** A Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing Plan Members to seek care outside of the traditional HMO network under certain situations or for certain treatment.
- **Maximum out-of-pocket (MOOP):** The most that you pay out-of-pocket during the calendar year for covered services.
- **Network:** Group of contracted providers, facilities and pharmacies for the plan.
- **Premium:** The periodic payment to Medicare, an insurance company, or a healthcare plan for health or prescription drug coverage.
- **Prior Authorization:** For certain services or prescription drugs, you will need to get approval in advance from your insurance provider before obtaining the services or drugs. Your Primary Care Physician (PCP) or specialist may submit prior authorization to your insurance for the prior authorization.

7 County Expansion for 2021!



Service Area

GlobalHealth's Generations Medicare Advantage Plans are available in 51 Oklahoma counties. (See back cover of guide for complete service area).

Provider Network* as of September 2020

GlobalHealth's Generations Medicare Advantage Plans have a strong network of providers and facilities including:

Tulsa

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

Oklahoma City

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

*This is not a full list of providers. Other providers are available in our network. The provider network may change at any time. You will receive notice when necessary. To see if your local provider or hospital is in-network, visit www.GlobalHealth.com/search or call Customer Care at 1-844-280-5555 (TTY: 711).

What Makes Us Different?

Don't miss out on these great savings!

GlobalHealth's Generations Medicare Advantage Plans allow you to enjoy the benefits you currently receive from Original Medicare plus, vision and dental services, no referrals for in-network specialist visits, and many more money-saving benefits! ***Plus, we offer a new plan called Generations Classic Choice which allows you to visit certain out-of-network specialists.***

$0 Plans Start at $0 Per Month	***NO*** Referrals Required for In-Network Specialist Visits	**$0** Unlimited Primary Care Physician Visits	**NO DEDUCTIBLES** No Medical or Drug Deductibles
$0 $0 Copay on Medicare Covered Preventive Care	**LOW MOOP** Only $3,000 or $3,900 Depending on Plan	**90-DAY SUPPLY** of Prescription Drugs for As Low As $0 Copay[1]	**$50** Quarterly Over-the-Counter Allowance

[1]Applicable to 90-day supply at preferred retail and mail order pharmacies. Not applicable to all Tiers. Only applicable to plans with prescription drug coverage.

FITNESS BENEFIT

Up to a
$300
Supplemental Eyewear Benefit

Plus a Routine Vision Exam

OKLAHOMA BASED

Up to
$1,500

in Dental Allowances

STRONG PROVIDER NETWORK

Up to a
$1,000

Hearing Aid Benefit

LOCAL CUSTOMER CARE

TRANSPORTATION BENEFIT[2]

[2]Only members diagnosed with defined disease states qualify. Please visit www.GlobalHealth.com to review Evidence of Coverage for more details.

2021 Benefits at a Glance

GlobalHealth Generations Medicare Advantage Plans

Effective January 1, 2021 - December 31, 2021

	Medicare Advantage Plans without Prescription Drug Coverage	Medicare Advantage Plans with Prescription Drug Coverage			
	GENERATIONS VALUE (HMO)	GENERATIONS CLASSIC (HMO)	GENERATIONS CLASSIC CHOICE (HMO-POS)		GENERATIONS SELECT (HMO)
			In-Network	Out-of-Network	
BENEFIT	**YOU PAY**				
Premium	$0	$0	$10		$29
Deductible	$0	$0	$0		$0
MOOP	$3,000	$3,900	$3,900	$10,000	$3,900
Primary Care Physician	$0	$0	$0	Not Covered	$0
Specialist	$40 copay	$45 copay	$45 copay	You pay 30% of the cost per visit	$35 copay
Preventive Care	You pay nothing	You pay nothing	You pay nothing	Not covered	You pay nothing
Inpatient Hospital Care	$400 copay per day (Days 1–5) You pay nothing per day (Days 6–190)	$395 copay per day (Days 1–5) You pay nothing per day (Days 6–190)	$395 copay per day (Days 1–5) You pay nothing per day (Days 6–190)	You pay 30% of the cost per visit	$325 copay per day (Days 1–5) You pay nothing per day (Days 6–190)
Outpatient Surgery and Hospital Services	$250 copay - Ambulatory Surgery Center $320 - Hospital	$250 copay - Ambulatory Surgery Center $320 - Hospital	$250 copay - Ambulatory Surgery Center $320 - Hospital	You pay 30% of the cost per visit	$250 copay - Ambulatory Surgery Center $320 - Hospital
Diagnostic Tests, X-rays, Lab Services and Radiology	You pay nothing for x-rays; $5 copay for labs; $50 copay for therapeutic radiology; $100 copay for sleep studies in outpatient facility	You pay nothing for labs and x-rays; $50 copay for therapeutic radiology; $100 copay for sleep studies in outpatient facility	You pay nothing for labs and x-rays; $50 copay for therapeutic radiology; $100 copay for sleep studies in outpatient facility	Not covered	You pay nothing for labs and x-rays; $40 copay for therapeutic radiology; $100 copay for sleep studies in outpatient facility

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at: https://www.globalhealth.com/medicare-advantage/member-materials

2021 Benefits at a Glance

GlobalHealth Generations Medicare Advantage Plans

Effective January 1, 2021 - December 31, 2021

	Medicare Advantage Plans without Prescription Drug Coverage	Medicare Advantage Plans with Prescription Drug Coverage			
	GENERATIONS VALUE (HMO)	GENERATIONS CLASSIC (HMO)	GENERATIONS CLASSIC CHOICE (HMO-POS)		GENERATIONS SELECT (HMO)
			In-Network	Out-of-Network	
BENEFIT	**YOU PAY**				
MRI, PET, CT Scans	$180 copay in PCP, specialist, urgent care, or free-standing radiology facility; $250 copay in outpatient hospital	$180 copay in PCP, specialist, urgent care, or free-standing radiology facility; $250 copay in outpatient hospital	You pay $180 copay in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a non-preferred setting	Not covered	$180 copay in PCP, specialist, urgent care, or free-standing radiology facility; $250 copay in outpatient hospital
Ambulance Services	$250 copay	$250 copay	$250 copay	$250 copay	$250copay
Emergency Room	$120 copay	$90 copay	$90 copay	$90 copay	$85 copay
Urgent Care	$15 copay	$30 copay	$30 copay	$30 copay	$25 copay
Chiropractic	$20 copay	$20 copay	$20 copay	Not covered	$20 copay
Home Health	You pay nothing	You pay nothing	You pay nothing	Not covered	You pay nothing
Diabetes Supplies	You pay nothing	You pay nothing	You pay nothing	Not covered	You pay nothing

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at: https://www.globalhealth.com/medicare-advantage/member-materials

2021 Benefits at a Glance

Prescription Drug Coverage

Effective January 1, 2021 - December 31, 2021

Generations Classic, Generations Classic Choice & Generations Select

Deductible: $0

Note: Generations Value does not include Prescription Drug Coverage

30-DAY PREFERRED RETAIL AND MAIL ORDER			
DRUG TYPE	**GENERATIONS CLASSIC**	**GENERATIONS CLASSIC CHOICE**	**GENERATIONS SELECT**
Tier 1 - Preferred Generics	$5	$5	$3
Tier 2 - Generics	$15	$15	$13
Tier 3 - Preferred Brand Name	$42	$42	$40
Tier 4 - Non-Preferred Drugs	40%	40%	40%
Tier 5 - Specialty	33%	33%	33%

90-DAY PREFERRED RETAIL AND MAIL ORDER			
DRUG TYPE	**GENERATIONS CLASSIC**	**GENERATIONS CLASSIC CHOICE**	**GENERATIONS SELECT**
Tier 1 - Preferred Generics	$0	$0	$0
Tier 2 - Generics	$0	$0	$0
Tier 3 - Preferred Brand Name	$84	$84	$80
Tier 4 - Non-Preferred Drugs	40%	40%	40%

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

Costs are higher at a Standard Pharmacy

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at: https://www.globalhealth.com/medicare-advantage/member-materials

2021 Benefits at a Glance

Additional Benefits Not Covered Under Original Medicare

Effective January 1, 2021 - December 31, 2021

GENERATIONS VALUE (HMO)	
Routine Vision Exam	You pay nothing for up to 1 visit per year
Routine Eyewear Benefit	Plan pays up to a $300 calendar year maximum
Dental	Plan pays up to a $1,500 calendar year maximum for preventive and comprehensive services
Over-the-Counter Benefit	$50 quarterly benefit for over-the-counter (OTC) health and wellness products available through our mail order service. If $50 is not used in a quarter, the balance does not carry over. Prices include shipping, handling, and sales tax.
Fitness Benefit	You pay nothing at an in-network fitness facility or for up to 2 home fitness kits per year
Routine Hearing Exam	You pay nothing for up to 1 visit per year to determine the need for hearing aids
Hearing Aids	Plan pays up to a $1,000 calendar year maximum for hearing aids and fitting
GENERATIONS CLASSIC (HMO)	
Routine Vision Exam	You pay nothing for up to 1 visit per year
Routine Eyewear Benefit	Plan pays up to a $200 calendar year maximum
Dental	Plan pays up to a $1,000 calendar year maximum for preventive and comprehensive services
Over-the-Counter Benefit	$50 quarterly allowance for over-the-counter (OTC) health and wellness products available through our mail order service. If $50 is not used in a quarter, the balance does not carry over. Prices include shipping, handling, and sales tax.
Fitness Benefit	You pay nothing at an in-network fitness facility or for up to 2 home fitness kits per year
Routine Hearing Exam	You pay nothing for up to 1 visit per year to determine the need for hearing aids
Hearing Aids	Plan pays up to $500 calendar year maximum for hearing aids and fitting

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

2021 Benefits at a Glance

Additional Benefits Not Covered Under Original Medicare

Effective January 1, 2021 - December 31, 2021

GENERATIONS CLASSIC CHOICE (HMO-POS)	
Routine Vision Exam	You pay nothing for up to 1 in-network visit per year
Routine Eyewear Benefit	Plan pays up to a $200 calendar year maximum in-network or out-of-network
Dental	Plan pays up to a $1,000 calendar year maximum in-network for preventive and comprehensive services
Over-the-Counter Benefit	$50 quarterly benefit for over-the-counter (OTC) health and wellness products available through our in-network mail order service. If $50 is not used in a quarter, the balance does not carry over. Prices include shipping, handling, and sales tax.
Fitness Benefit	You pay nothing at an in-network fitness facility or up to 2 home fitness kits per year
Routine Hearing Exam	You pay nothing for up to 1 in-network visit per year to determine the need for hearing aids
Hearing Aids	Plan pays up to $500 calendar year maximum for hearing aids and fittings in-network

GENERATIONS SELECT (HMO)	
Routine Vision Exam	You pay nothing for up to 1 visit per year
Routine Eyewear Benefit	Plan pays up to a $200 calendar year maximum
Dental	Plan pays up to $1,000 calendar year maximum for preventive and comprehensive services
Over-the-Counter Benefit	$50 quarterly benefit for over-the-counter (OTC) health and wellness products available through our mail order service. If $50 is not used in a quarter, the balance does not carry over. Prices include shipping, handling, and sales tax.
Fitness Benefit	You pay nothing at an in-network fitness facility or for up to 2 home fitness kits per year
Routine Hearing Exam	You pay nothing for up to 1 visit per year to determine the need for hearing aids
Hearing Aids	Plan pays up to $500 calendar year maximum for hearing aids and fitting

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

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GlobalHealth

Generations Medicare
Advantage Plans

2021 Summary of Benefits

January 1 – December 31, 2021

Generations Medicare Advantage Plan Options:

Generations Value (HMO)

Generations Classic (HMO)

Generations Classic Choice (HMO-POS)

Generations Select (HMO)

1-844-280-5555 (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/medicare

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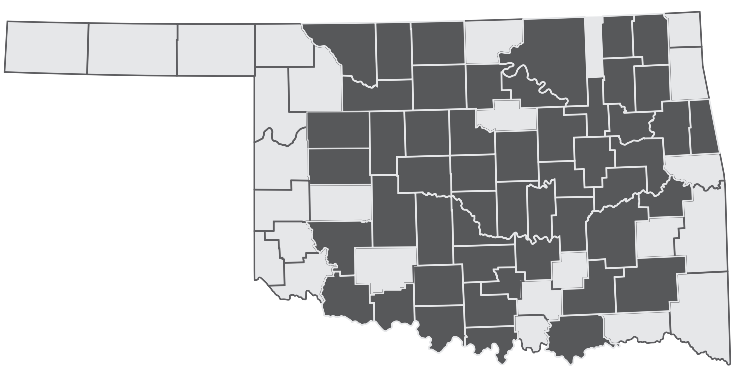
GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.

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 1-844-280-5555 (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 Oklahoma:



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

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services. For Generations Classic Choice (HMO-POS) check the Evidence of Coverage for out-of-network coverage options.

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 (1-800-633-4227). TTY users should call 1-877-486-2048.

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

For more information, please call us at 1-844-280-5555 (TTY: 711), or visit us at www.GlobalHealth.com.

2021

Medicare Advantage Plan

Without Prescription Drug Coverage

(No Medicare Part D)

Generations Value (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,000 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	You pay $400 copay per day (Days 1-5); You pay nothing per day (Days 6-190); you pay nothing for COVID-19 treatment	
Outpatient Hospital Services [1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $300 copay per visit; you pay nothing for COVID-19 treatment • You pay $320 copay per visit	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.
Doctor Visits • **Primary** • **Specialists**	• You pay nothing • You pay $40 copay per visit; you pay nothing for COVID-19 treatment	

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Preventive Care	You pay nothing for Medicare-covered preventive services	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $120 copay per visit; you pay nothing for COVID-19 treatment	If you are admitted to the hospital within 24 hours, or outpatient surgical services or observation services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $15 copay per visit; you pay nothing for COVID-19 treatment	
Ambulatory Surgery Center[1, 2]	You pay $250 copay per visit; waived if admitted to acute care	
Diagnostic Services/Labs/Imaging • **Diagnostic radiology service (e.g., MRI)**[1,2] • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology**[1,2] • **Outpatient x-rays**	• You pay $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; you pay $250 copay per visit in a nonpreferred setting • You pay $5 copay per visit; you pay nothing for COVID-19 treatment • You pay $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $50 copay per visit • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $40 copay per visit • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	Routine exam is for the evaluation for hearing aids and limited to 1 per year. Our plan pays up to a total of $1,000 for hearing aids per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Dental Services **• Preventive Dental Services** **• Oral exam (2 per year)** **• X-rays (2 sets per year)** **• Cleaning (2 per year)** **• Comprehensive Dental Services** **• Non-routine services** **• Diagnostic services** **• Restorative services** **• Endodontics** **• Periodontics** **• Extractions** **• Prosthodontics** **• Medicare-covered exams[1,2]**	• You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays up to a total of $1,500 for preventive and comprehensive dental services per year, including dentures.
Vision Services **• Medicare-covered eye exam** **• Supplemental eye exam (1 per year)** **• Eyeglasses or contact lenses after cataract surgery** **• Supplemental eyeglasses (frames and lenses) or contacts**	• You pay nothing • You pay nothing • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	Supplemental eye exam limited to 1 per year. Choice of 1 pair of supplemental eyeglasses or contacts. Our plan pays up to a total of $300 for all supplemental eyewear per year.
Mental Health Services **• Inpatient visit [1,2]** **• Outpatient mental health visit** **• Outpatient psychiatric visit**	• You pay $275 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay nothing	
Acupuncture	You pay $25 copay per visit	12 visits for chronic lower back pain (LBP) with additional 8 sessions if demonstrating improvement
Skilled Nursing Facility (SNF)[1,2]	You pay nothing per day (Days 1-20); You pay $184 copay per day (Days 21-100); You pay nothing for COVID-19 treatment	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Rehabilitation Services[1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $20 copay per visit • You pay $20 copay per visit	Prior authorization is required. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
Medicare Part B Drugs[1,2,3]	You pay 20% of the cost; You pay nothing for COVID-19 treatment	This plan does not cover Part D prescription drugs.
Home Health Services[1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)**[1] • **Prosthetics and related supplies (e.g., braces, artificial limbs)**[1] • **Standard diabetic testing supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies; You pay 20% of the cost for external devices and medical supplies. • You pay nothing	Continuous Glucose Monitors (CGM) are considered Durable Medical Equipment. Please see Durable Medical Equipment for CGM cost-share information.
Chiropractic Services	You pay $20 copay per visit	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $40 copay per visit • You pay $40 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

2021

Medicare Advantage Prescription Drug (MA-PD) Plans

Generations Classic (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay $3,900 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	You pay $395 copay per day (Days 1-5); You pay nothing per day (Days 6-190); You pay nothing for COVID-19 treatment	
Outpatient Hospital Services [1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $300 copay per visit; you pay nothing for COVID-19 treatment • You pay $320 copay per visit	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.
Doctor Visits • **Primary** • **Specialists**	• You pay nothing • You pay $45 copay per visit; you pay nothing for COVID-19 treatment	
Preventive Care	You pay nothing for Medicare-covered preventive services	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $90 copay per visit; You pay nothing for COVID-19 treatment	If you are admitted to the hospital within 24 hours, or outpatient surgical services or observation services are needed within 24 hours, you do not have to pay your copay for emergency care.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Ambulatory Surgery Center[1, 2]	You pay $250 copay per visit; waived if admitted to acute care	
Urgently Needed Services	You pay $30 copay per visit; You pay nothing for COVID-19 treatment	
Diagnostic Services/Labs/Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; you pay $250 copay per visit in a non-preferred setting • You pay nothing • You pay $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $50 copay per visit • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $45 copay per visit • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	Routine exam is for the evaluation for hearing aids and limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.
Dental Services • **Preventive Dental Services** - **Oral exam (2 per year)** - **X-rays (2 sets per year)** - **Cleaning (2 per year)** • **Comprehensive Dental Services** - **Non-routine services** - **Diagnostic services** - **Restorative services** - **Endodontics** - **Periodontics** - **Extractions** - **Prosthodontics** • **Medicare-covered exams [1,2]**	• You pay nothing • 0% coinsurance for fillings, diagnostics, and nitrous oxide and sedation; other services 30% coinsurance • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays a total of $1,000 for preventive and comprehensive dental services per year, including dentures.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Eyeglasses or contact lenses after cataract surgery** • **Supplemental eyeglasses (frames and lenses) or contacts**	• You pay nothing • You pay nothing • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts. Our plan pays up to a total of $200 for all supplemental eyewear per year.
Mental Health Services • **Inpatient visit**[1,2] • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $275 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay nothing	
Acupuncture	You pay $25 copay per visit	12 visits for chronic lower back pain (LBP) with additional 8 sessions if demonstrating improvement.
Skilled Nursing Facility (SNF)[1,2]	You pay nothing per day (Days 1-20); You pay $184 copay per day (Days 21-100); You pay nothing for COVID-19 treatment	Our plan covers up to 100 days in an SNF. Prior hospital stay is not required.
Rehabilitation Services[1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $20 copay per visit • You pay $20 copay per visit	If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Transportation	Not covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
Medicare Part B Drugs [1,2,3]	You pay 20% of the cost; You pay nothing for COVID-19 treatment	
Home Health Services [1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)**[1] • **Prosthetics and related supplies (e.g., braces, artificial limbs)**[1] • **Standard diabetic testing supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies. You pay 20% of the cost for external devices and medical supplies. • You pay nothing	Continuous Glucose Monitors (CGM) are considered Durable Medical Equipment. Please see Durable Medical Equipment for CGM cost-share information.
Chiropractic Services	You pay $20 copay per visit	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $45 copay per visit • You pay $45 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
Phase 2: Initial Coverage (You don't have a deductible)	**Preferred Retail Rx 30-day supply**	**Standard Retail Rx 30-day supply**	**Preferred Retail and Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	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 90 days supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay nothing	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 40% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	
Phase 3: Coverage Gap Stage After your prescription costs reach $4,130		For Tier 1 generic drugs, GlobalHealth members get either the standard Medicare Part D discount or continue to pay the same amount as in the initial coverage stage, whichever is less. Members pay 25% of the cost for generic drugs in other tiers. The Medicare Coverage Gap Discount Program of 70% is applied to the copayment during the Initial Coverage Stage, for Tier 1 brands. Members also have additional gap coverage for Tier 3 oral anti-diabetics. Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.		You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550. This amount and rules for counting costs toward this amount have been set by Medicare.
Phase 4: Catastrophic Coverage Stage After you have paid $6,550 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.70 for generics/$9.20 for brand names.		

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.
*Costs for 90-day supply are higher at a Standard Pharmacy
For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

Generations Classic Choice (HMO-POS) Summary of Benefits

January 1, 2021 – December 31, 2021

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

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay $10		You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing		This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay $3,900 annually	You pay combined $10,000 annually	Your in-network limit and out-of-network limit go towards the $10,000 maximum out-of-pocket.
Inpatient Hospital Coverage[1,2]	You pay $395 copay per day (Days 1-5); You pay nothing per day (Days 6-190); You pay nothing for COVID-19 treatment	You pay 30% of the cost per visit	
Outpatient Hospital Services[1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• 20% of the cost per visit • You pay $300 copay per visit; You pay nothing for COVID-19 treatment • You pay $320 copay per visit	• Not covered • You pay 30% of the cost per visit • Not covered	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies. For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage.

1 = Prior Authorization Required
2 = Referral Required

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Doctor Visits • **Primary** • **Specialists**	• You pay nothing • You pay $45 per visit; you pay nothing for COVID-19 treatment	• Not covered • You pay 30% of the cost per visit	For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage.
Preventive Care	You pay nothing for Medicare-covered services	Not Covered	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $90 copay per visit; You pay nothing for COVID-19 treatment	You pay $90 copay per visit; You pay nothing for COVID-19 treatment	If you are admitted to the hospital within 24 hours, or outpatient surgical or observation services services are needed within 24 hours, you do not have to pay your copay for emergency care.
Ambulatory Surgery Center[1, 2]	You pay $250 copay per visit; waived if admitted to acute care	Not covered	

1 = Prior Authorization Required
2 = Referral Required

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Urgently Needed Services	You pay $30 copay per visit; You pay nothing for COVID-19 treatment	You pay $30 copay per visit; You pay nothing for COVID-19 treatment	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)** [1,2] • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology**[1,2] • **Outpatient X-rays**	• You pay $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a nonpreferred setting • You pay nothing • You pay $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $50 copay per visit • You pay nothing	Not covered	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $45 copay per visit • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	• Not Covered • You pay 30% of the cost per visit • Not Covered • Not Covered	Routine exam is for the evaluation for hearing aids and limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Dental Services Preventive **• Dental Services** **- Oral exam (2 per year)** **- X-rays (2 sets per year)** **- Cleaning (2 per year)** **• Comprehensive Dental Services** **- Non-routine services** **- Diagnostic services** **- Restorative services** **- Endodontics** **- Periodontics** **- Extractions** **- Prosthodontics** **• Medicare-covered exams[1,2]**	• You pay nothing • 0% coinsurance for fillings, diagnostics, and nitrous oxide and sedation; other services 30% coinsurance • You pay based on setting (doctor's office, emergency room, etc.)	Not Covered	Our plan pays a total of $1,000 for preventive and comprehensive dental services per year including dentures.
Vision Services **• Medicare-covered eye exam** **• Supplemental eye exam** **• Eyeglasses or contact lenses after cataract surgery** **• Supplemental eyeglasses (frames and lenses) or contacts**	• You pay nothing • You pay nothing • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	• You pay 30% of the cost per visit • Not covered • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts. Our plan pays up to a total of $200 for all supplemental eyewear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit**[1,2] • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $275 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay nothing	Not Covered	
Acupuncture	You pay $25 per vist	Not Covered	Limited to 12 visits for chronic lower back pain with 8 additional visits if demonstrating improvement.
Skilled Nursing Facility (SNF)[1,2]	You pay nothing per day (Days 1-20); You pay $184 copay per day (Days 21-100); You pay nothing for COVID-19 treatment	You pay 30% of the cost per visit	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services[1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy**	• You pay $20 copay per visit • You pay $20 copay per visit	Not Covered	If these services are provided in your home, then the home health cost-sharing applies instead.

1 = Prior Authorization Required
2 = Referral Required

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Ambulance	You pay $250 copay per occurrence	You pay 30% of the cost per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share for the ambulance services.
Transportation	Not Covered	Not Covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
Medicare Part B Drugs[1,2,3]	You pay 20% of the cost; You pay nothing for COVID-19 treatment	Not Covered	
Home Health Services[1,2]	You pay nothing	Not Covered	You pay regular cost-sharing for services or equipment not provided through a home health agency.

1 = Prior Authorization Required
2 = Referral Required
3 = May be subject to Part B step therapy.

PREMIUM AND BENEFITS	GENERATIONS CLASSIC CHOICE IN-NETWORK	GENERATIONS CLASSIC CHOICE OUT-OF-NETWORK	WHAT YOU SHOULD KNOW
Medical Equipment/ Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]** • **Prosthetics and related supplies (e.g. braces, artificial limbs)[1]** • **Standard diabetic testing supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies. You pay 20% of the cost for external devices and medical supplies. • You pay nothing	Not Covered	Continuous Glucose Monitors (CGM) are considered Durable Medical Equipment. Please see Durable Medical Equipment for CGM cost-share information.
Chiropractic Services	You pay $20 copay per visit	Not Covered	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $45 copay per visit • You pay $45 copay per visit	You pay 30% of the cost per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC CHOICE			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
Phase 2: Initial Coverage (You don't have a deductible)	**Preferred Retail Rx 30-day supply**	**Standard Retail Rx 30-day supply**	**Preferred Retail and Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	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 90 days supply). For more information on the additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay nothing	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 40% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	
Phase 3: Coverage Gap Stage After your prescription costs reach $4,130		For Tier 1 generic drugs, GlobalHealth members get either the standard Medicare Part D discount or continue to pay the same amount as in the initial coverage stage, whichever is less. Members pay 25% of the cost for generic drugs in other tiers. The Medicare Coverage Gap Discount Program of 70% is applied to the copayment during the Initial Coverage Stage, for Tier 1 brands. Members also have additional gap coverage for Tier 3 oral anti-diabetics. Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.		You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550. This amount and rules for counting costs toward this amount have been set by Medicare.
Phase 4: Catastrophic Coverage Stage After you have paid $6,550 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.70 for generics/$9.20 for brand names.		

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.

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

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

Generations Select (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $29	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,900 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	You pay $325 copay per day (Days 1-5); You pay nothing per day (Days 6-190); You pay nothing for COVID-19 treatment	
Outpatient Hospital Services[1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $150 copay per visit; you pay nothing for COVID-19 treatment • You pay $320 copay per visit	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Doctor Visits • **Primary** • **Specialists**	• You pay nothing • You pay $35 copay per visit; you pay nothing for COVID-19 treatment	
Preventive Care	You pay nothing for all Medicare-covered preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $85 copay per visit; You pay nothing for COVID-19 treatment	If you are admitted to the hospital within 24 hours, or outpatient surgical services or observation services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $25 copay per visit; You pay nothing for COVID-19 treatment	
Ambulatory Surgery Center[1,2]	You pay $250 copay per visit; waived if admitted to acute care	
Diagnostic Services/Labs/Imaging • **Diagnostic radiology service (e.g., MRI)**[1,2] • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology**[1,2] • **Outpatient x-rays**	• You pay $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a non-preferred setting • You pay nothing • You pay $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $40 copay per visit • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received during an office visit.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $35 copay per visit • You pay nothing • No cost-share; You are responsible for the cost over your benefit allowance	Routine exam is for the evaluation for hearing aids and limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.
Dental Services • **Preventive Dental Services** - **Oral exam (2 per year)** - **X-rays (2 sets per year)** - **Cleaning (2 per year)** • **Comprehensive Dental Services** - **Non-routine services** - **Diagnostic services** - **Restorative services** - **Endodontics** - **Periodontics** - **Extractions** - **Prosthodontics** • **Medicare-covered exams[1,2]**	• You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays up to a total of $1,000 for preventive and comprehensive dental services per year, including dentures.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Eyeglasses or contact lenses after cataract surgery** • **Supplemental eyeglasses (frames and lenses) or contacts**	• You pay nothing • You pay nothing • You pay nothing • No cost-share. You are responsible for the cost over your benefit allowance.	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts. Our plan pays up to a total of $200 for all supplemental eyewear per year.
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $250 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay nothing	
Acupuncture	You pay $25 copay per visit	12 visits for chronic lower back pain (LBP) with additional 8 sessions if demonstrating improvement.
Skilled Nursing Facility (SNF)[1,2]	You pay nothing per day (Days 1-20); You pay $184 copay per day (Days 21-100); You pay nothing for COVID-19 treatment	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $10 copay per visit • You pay $10 copay per visit	If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
Medicare Part B Drugs[1,2,3]	You pay 20%; You pay nothing for COVID-19 treatment	
Home Health Services[1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]** • **Prosthetics (e.g., braces, artificial limbs)[1]** • **Standard diabetic testing supplies.**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies; You pay 20% of the cost for external devices and medical supplies • You pay nothing	Continuous Glucose Monitors (CGM) are considered Durable Medical Equipment. Please see Durable Medical Equipment for CGM cost-share information.
Chiropractic Services	You pay $20 copay per visit	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $35 copay per visit • You pay $35 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
Phase 2: Initial Coverage (You don't have a deductible)	**Preferred Retail Rx 30-day supply**	**Standard Retail Rx 30-day supply**	**Preferred Retail and Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $3 copay per fill	You pay $8 copay per fill	You pay nothing	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 90-day supply). For more information on the additional pharmacies' specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $13 copay per fill	You pay $18 copay per fill	You pay nothing	
Tier 3: Preferred Brand	You pay $40 copay per fill	You pay $45 copay per fill	You pay $80 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 40% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	
Phase 3: Coverage Gap Stage After your prescription costs reach $4,130		For Tier 1 generic drugs, GlobalHealth members get either the standard Medicare Part D discount or continue to pay the same amount as in the initial coverage stage, which-ever is less. Members pay 25% of the cost for generic drugs in other tiers. The Medicare Coverage Gap Discount Program of 70% is applied to the copayment during the Initial Coverage Stage, for Tier 1 brands. Members also have additional gap coverage for Tier 3 oral anti-diabetics. Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs.		You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,550. This amount and rules for counting costs toward this amount have been set by Medicare.
Phase 4: Catastrophic Coverage Stage After you have paid $6,550 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.70 for generics/$9.20 for brand names.		

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.

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

For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at: https://www.globalhealth.com/medicare-advantage/member-materials

GlobalHealth

Customer Care: 1-844-280-5555 (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/medicare-advantage/member-materials

Provider Directory: www.GlobalHealth.com/search
Pharmacy Directory: www.GlobalHealth.com/pharmacy-directory

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

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal. You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Call Customer Care at 1-844-280-5555 for more information.

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

GlobalHealth Medicare Advantage Plans

Attestation of Eligibility for an Enrollment Period

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

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

- ❑ I am new to Medicare.
- ❑ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on: M M/D D/Y Y Y Y
- ❑ I recently was released from incarceration. I was released on: M M/D D/Y Y Y Y
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on: M M/D D/Y Y Y Y
- ❑ I recently obtained lawful presence status in the United States. I got this status on: M M/D D/Y Y Y Y
- ❑ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on: M M/D D/Y Y Y Y
- ❑ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on: M M/D D/Y Y Y Y
- ❑ I have both Medicare and Medicaid (or my state helps me pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on: M M/D D/Y Y Y Y
- ❑ I recently left a PACE program on: M M/D D/Y Y Y Y

GlobalHealth Medicare Advantage Plans

Attestation of Eligibility for an Enrollment Period (cont.)

- ❑ I recently involuntarily lost my credible prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on: M M/D D/Y Y Y Y
- ❑ I am leaving employer or union coverage on: M M/D D/Y Y Y Y
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on: M M/D D/Y Y Y Y
- ❑ I was enrolled in a Special Needs Plan (SNP) , but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on: M M/D D/Y Y Y Y
- ❑ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ❑ I was enrolled in a plan(s) that are experiencing financial difficulties to such an extent that a state or territorial regulatory authority has placed the organization in receivership on: M M/D D/Y Y Y Y Plan Name: _____
- ❑ I was enrolled in a plan that identified with the low performing icon (LPI). Plan Name: _____

If none of these statements applies to you or you're not sure, please contact GlobalHealth at 1-844-280-5555 (TTY users should call 711) to see if you are eligible to enroll. We are open 8:00 a.m. to 8:00 p.m., 7 days a week (October 1 - March 31) and Monday - Friday (April 1- September 30).

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OMB No. 0938-1378
Expires:7/31/2023

INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:
GlobalHealth
Attn: Eligibility and Enrollment
P.O. Box 1747
Oklahoma City, OK 73101-1747

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call GlobalHealth at 1-844-322-8322 TTY users can call 711

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a GlobalHealth al 1-844-322-8322/711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

OMB No. 0938-1378
Expires:7/31/2023

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

❑ Generations Value (MA-Only) $0 per month

❑ Generations Classic Choice (MA-PD) $10 per month

❑ Generations Classic (MA-PD) $0 per month

❑ Generations Select (MA-PD) $29 per month

FIRST name:	**LAST name:**	**(Optional) Middle Initial:**

Birth date: (MM/DD/YYYY)	**Sex:** ❑ Male ❑ Female	**Phone number:** ( ) -

Permanent Residence street address (Don't enter a PO Box):

City:	**(Optional) County:**	**State:**	**ZIP Code:**

Mailing address, if different from your permanent address (PO Box allowed):

Street address: City: State: ZIP Code:

Your Medicare information:

Medicare Number: __ __ __ __ - __ __ __ - __ __ __ __

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to GlobalHealth? ❑ Yes ❑ No

Name of other coverage: _____ Member number of this coverage: _____ Group number of this coverage: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in GlobalHealth.
- By joining this Medicare Advantage Plan, I acknowledge that GlobalHealth will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by the Federal law that authorize the collection of this information (see Privacy act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my GlobalHealth coverage begins, I must get all of my medical and prescription drug benefits from GlobalHealth. Benefits and services provided by GlobalHealth and contained in my GlobalHealth "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor GlobalHealth will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	**Address:**
Phone number: ( ) -	**Relationship to enrollee:**

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

❑ Spanish

Select if you want us to send you information in an accessible format.

❑ Large print

Please contact GlobalHealth at 1-844-280-5555 if you need information in an accessible format other than what's listed above. Our office hours are 8:00 AM to 8:00 PM Central, Seven days a week (Oct 1 – Mar 31), 8:00 AM to 8:00 PM Central, Monday through Friday (Apr 1 – Sept 30). TTY users can call 711.

Do you work? ❑ Yes ❑ No Does your spouse work? ❑ Yes ❑ No

List your Primary Care Physician (PCP), clinic, or health center:

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT), and credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRD) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay GlobalHealth the Part D-IRMAA.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

After Enrollment
What Happens Next?

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

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

QUESTIONS? You can call our friendly Customer Care for answers to your questions
at 1-844-280-5555 (TTY: 711). 8 a.m. to 8 p.m.
7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)

How to Easily Access Your Benefit Information

Are you looking for other ways to view our plans' cost shares, network providers and other information included in a GlobalHealth Generations Medicare Advantage Plan? Below are additional ways to view our plan benefits.

Visit the GlobalHealth Website

Our website includes the below information for quick and easy access. Visit www.GlobalHealth.com, then click on Medicare.

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

Find us on

GlobalHealth's Facebook Page also provides information and updates to members. Visit our page today: www.facebook.com/GlobalHealthInc

Important Phone Numbers

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

IMPORTANT PHONE NUMBERS:	WHY CALL?
Customer Care **1-844-280-5555 (TTY: 711)** **8 am - 8 pm** **7 days a week (Oct 1 - Mar 31)** **Monday - Friday (Apr 1 - Sept 30)**	**Speak to a Member Advocate:** • If you've lost important plan documents, like your Member ID card or your Summary of Benefits. • If you need to obtain authorization for a service or procedure. • If you need to know if a specific procedure or service is covered. • If you have benefit or coverage questions. • If you need help locating a network provider or pharmacy. • If you need to verify if a prescription is on the drug formulary.
Fraud, Waste, and Abuse Hotline **1-877-280-5852** **All communications are confidential and anonymous.**	**Report any healthcare fraud, such as:** • Provider bills you for medical services, supplies or items that were not provided. • Provider performs medically unnecessary services to obtain the insurance payment. • Someone steals your personal information to submit false claims to obtain the insurance benefit. • Someone pretends to represent Medicare, the Social Security Administration or an insurance plan for the purpose of obtaining personal information.

Non-Discrimination Notice

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

GlobalHealth:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
    - o Qualified sign language interpreters
    - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- **Provides free language services to people whose primary language is not English, such as:**
    - o Qualified interpreters
    - o Information written in other languages

If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free).

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **ATTN: Compliance & Legal Services, 210 Park Ave., Suite 2800, Oklahoma City, OK 73102-5621 or Email: compliance@globalhealth.com.** You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20211, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-280-5555 (TTY: 711)。

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

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

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

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

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

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

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

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

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

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

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

توجه: اگر شما به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید.

1-844-280-5555 (TTY: 711).

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GlobalHealth
Transition of Care Request Form

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

INSTRUCTIONS FOR COMPLETING TRANSITION OF CARE REQUEST FORM

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

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

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

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

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

GlobalHealth Transition of Care Request Form (cont.)

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

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

_____

Describe conditions from question #7 requiring transition of care:

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

Signature of Patient	Date (mm/dd/yyyy)

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

Medicare Star Ratings

What are Star Ratings?

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

Why are Star Ratings important to me?

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

What do the plan ratings measure?

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

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

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

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

Learn More About Plan Ratings

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

Please see the Star Ratings in the back pocket of your All-in-One Guide.

FORMS FOR AGENT USE ONLY

GlobalHealth Generations Medicare Advantage Plans

Receipt of Enrollment

To be filled out by Agent.

Confirmation #: _____

Application Date: ____/____/____

Proposed Effective Date: ____/____/____

Plan Name: _____

Agent Name: _____

Agent Phone Number: ____—____—____

Agent ID (Optional): _____

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

Please tear out to keep for your records.

If you have any questions regarding your plan benefits, contact **Customer Care**:

1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.
7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)

Beneficiary Signature: _____ Date: _____

Agent Signature: _____ Date: _____

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Agent Enrollment Attestation

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

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

1. ☐ Enrollment form is complete and accurate; correct plan selected.
2. ☐ Reviewed Summary of Benefits with enrollee including premium, covered benefits, and applicable deductibles, coinsurance, and copays.
3. ☐ Reviewed Formulary and drug tiers and Coverage Gap.
4. ☐ Enrollee voices understanding of benefits, including Prescription Drug Coverage.
5. ☐ Reviewed Provider/Pharmacy Directory with enrollee and “in-network” requirements.
6. ☐ Beneficiary voices understanding that the plan may require prior authorization and understands provider network requirements.
7. ☐ Reviewed Primary Care Physician (PCP) requirements.
8. ☐ Enrollee voices understanding that he/she must continue to pay the Part B Premium.
9. ☐ Enrollee voices understanding of how he/she will make monthly premium payments, if applicable.
10. ☐ Notified enrollee to expect an enrollment confirmation letter from the plan.
11. ☐ Advised enrollee to use the new ID card from GlobalHealth rather than the Medicare red, white, and blue card beginning with enrollment effective date.
12. ☐ Reviewed late enrollment penalty (LEP), if applicable.
13. ☐ Answered enrollee’s questions and advised him/her to review plan materials carefully.

Enrollee Name _____

Agent Name _____

Agent Signature _____ Date _____

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Scope of Sales Appointment Confirmation

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

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

☐ Medicare Advantage Plan (Part C only)

☐ Medicare Advantage and Prescription Drug Plan (Part C and D)

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above.

Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[Plan Use Only:]	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

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Notes

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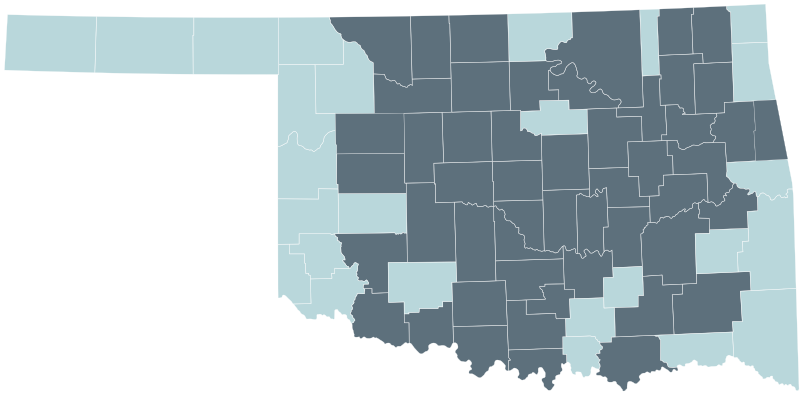
Notes

2021 Service Area



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

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