

Generations Valor (HMO)

EVIDENCE OF COVERAGE

January 1-December 31, 2026

GlobalHealth is an HMO plan with Medicare and Oklahoma Medicaid program contracts. Enrollment in GlobalHealth depends on contract renewal.

1-844-280-5555 (toll-free)

8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)

www.globalhealth.com

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of Generations Valor (HMO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost-sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). Hours are 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30). This call is free.

This plan, Generations Valor (HMO), is offered by GlobalHealth, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means GlobalHealth, Inc. When it says “plan” or “our plan,” it means Generations Valor (HMO).)

This information is available in different formats including, large print, braille, and audio CD. Please call our Customer Care at the numbers listed above if you need plan information in another format or language.

Language assistance services and auxiliary aids and services are available free of charge to provide information in accessible formats. Refer to the *Notice of Availability* for language assistance services and auxiliary aids and services.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You’ll get notice about any changes that may affect you at least 30 days in advance.

H3706_010_009EOC2026_C

Table of Contents

Table of Contents

CHAPTER 1:	Get started as a member	4
SECTION 1	You're a member of Generations Valor (HMO)	5
SECTION 2	Plan eligibility requirements	5
SECTION 3	Important membership material	6
SECTION 4	Summary of Important Costs	7
SECTION 5	More information about your monthly plan premium	8
SECTION 6	Keep our plan member record up to date	9
SECTION 7	How other insurance works with our plan	9
CHAPTER 2:	Phone numbers and resources	11
SECTION 1	Generations Valor (HMO) contacts	12
SECTION 2	Get help from Medicare	14
SECTION 3	State Health Insurance Assistance Program(SHIP)	16
SECTION 4	Quality Improvement Organization (QIO)	16
SECTION 5	Social Security	17
SECTION 6	Medicaid	17
SECTION 7	Railroad Retirement Board (RRB)	18
SECTION 8	If you have group insurance or other health insurance from an employer	19
CHAPTER 3:	Using our plan for your medical services	20
SECTION 1	How to get medical care as a member of our plan	21
SECTION 2	Use providers in our plan's network to get medical care	22
SECTION 3	How to get services in an emergency, disaster, or urgent need for care	26
SECTION 4	What if you're billed directly for the full cost of covered services?	28
SECTION 5	Medical services in a clinical research study	28
SECTION 6	Rules for getting care in a religious non-medical health care institution	30
SECTION 7	Rules for ownership of durable medical equipment	30
CHAPTER 4:	Medical Benefits Chart (what's covered and what you pay)	32
SECTION 1	Understanding your out-of-pocket costs for covered services	33
SECTION 2	The Medical Benefits Chart shows your medical benefits and costs	34
SECTION 3	Services that aren't covered by our plan (exclusions)	88

Table of Contents

CHAPTER 5:	Asking us to pay our share of a bill for covered medical services	91
SECTION 1	Situations when you should ask us to pay our share for covered services	92
SECTION 2	How to ask us to pay you back or pay a bill you got	93
SECTION 3	We'll consider your request for payment and say yes or no	94
CHAPTER 6:	Your rights and responsibilities	95
SECTION 1	Our plan must honor your rights and cultural sensitivities	96
SECTION 2	Your responsibilities as a member of our plan	106
CHAPTER 7:	If you have a problem or complaint (coverage decisions, appeals, complaints)	107
SECTION 1	What to do if you have a problem or concern	108
SECTION 2	Where to get more information and personalized help	108
SECTION 3	Which process to use for your problem	109
SECTION 4	A guide to coverage decisions and appeals	109
SECTION 5	Medical care: How to ask for a coverage decision or make an appeal	112
SECTION 6	How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon	118
SECTION 7	How to ask us to keep covering certain medical services if you think your coverage is ending too soon	122
SECTION 8	Taking your appeal to Levels 3, 4 and 5	125
SECTION 9	How to make a complaint about quality of care, waiting times, customer service, or other concerns	127
CHAPTER 8:	Ending membership in our plan	131
SECTION 1	Ending your membership in our plan	132
SECTION 2	When can you end your membership in our plan?	132
SECTION 3	How to end your membership in our plan	134
SECTION 4	Until your membership ends, you must keep getting your medical items and services through our plan	134
SECTION 5	Generations Valor (HMO) must end our plan membership in certain situations	135
CHAPTER 9:	Legal notices	136
SECTION 1	Notice about governing law	137
SECTION 2	Notice about nondiscrimination	137
SECTION 3	Notice about Medicare Secondary Payer subrogation rights	139
SECTION 4	Protections When Reporting Suspicions on Fraud, Waste, and/or Abuse	139

Table of Contents

CHAPTER 10: Definitions	140
--------------------------------------	------------

CHAPTER 1:

Get started as a member

CHAPTER 1: Get started as a member

SECTION 1 You're a member of Generations Valor (HMO)

Section 1.1 You're enrolled in Generations Valor (HMO), which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Generations Valor (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Generations Valor (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Generations Valor (HMO) doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Generations Valor (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Generations Valor (HMO) between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Generations Valor (HMO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Generations Valor (HMO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it
- You're a United States citizen or are lawfully present in the United States

CHAPTER 1: Get started as a member**Section 2.2 Plan service area for Generations Valor (HMO)**

Generations Valor (HMO) is available only to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Oklahoma: Caddo, Canadian, Carter, Cleveland, Creek, Garfield, Garvin, Grady, Hughes, Lincoln, Logan, Mayes, McClain, McIntosh, Muskogee, Okfuskee, Oklahoma, Okmulgee, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Rogers, Seminole, Tulsa, and Wagoner.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Generations Valor (HMO) if you're not eligible to stay a member of our plan on this basis. Generations Valor (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material**Section 3.1 Our plan membership card**

Use your member ID card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample member ID card:

		BARCODE HERE									
<Plan Name> Member ID: <XXXXXXXXXX> <First Name> <MI> <Last Name> PCP Name: <PCP Name> PCP Phone: <XXX-XX-XXXX> Copayments <table border="0"> <tr> <td>PCP</td> <td>SPEC</td> <td>ER</td> <td>H3706-<PBP #></td> </tr> <tr> <td><XX></td> <td><XX></td> <td><XX></td> <td>Effective: [cvg_eff_dt]</td> </tr> </table>		PCP	SPEC	ER	H3706-<PBP #>	<XX>	<XX>	<XX>	Effective: [cvg_eff_dt]	Customer Care: 1-844-280-5555 (TTY: 711) www.GlobalHealth.com 24/7 Nurse Line: 1-800-554-9371 (TTY: 711) Behavioral Health: 1-888-434-9202 (TTY: 711) In-Home Support Services: 1-855-485-9692 (TTY: 711) Transportation: 1-877-565-1612 (TTY: 711) Dental: 1-833-955-3423 (TTY: 1-800-466-7566) Vision: 1-800-884-6321 (TTY: 711) Hearing: 1-877-241-4736 (TTY: 711) Smart Wallet Benefit: 1-877-241-4736 (TTY: 711) Submit Claims to: GlobalHealth Claims Department P.O. Box 2718 Oklahoma City, OK 73101 EDI Payor ID: GHOKC0001	
PCP	SPEC	ER	H3706-<PBP #>								
<XX>	<XX>	<XX>	Effective: [cvg_eff_dt]								

CHAPTER 1: Get started as a member

DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Generations Valor (HMO) member ID card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan member ID card is damaged, lost, or stolen, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory*, <https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/medicare>, lists our current network providers and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Generations Valor (HMO) authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at www.GlobalHealth.com.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs

	Your Costs in 2026
Monthly plan premium*	\$0
* Your premium can be higher than this amount. Go to Section 4.1 for details.	
Maximum out-of-pocket amount	\$3,900
This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	
Primary care office visits	\$0 per visit
Specialist office visits	\$35 per visit
Inpatient hospital stays	Days 1-7: \$295

CHAPTER 1: Get started as a member

	Your Costs in 2026
	Days 8-90: \$0
	Days 91-190: \$0

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Generations Valor (HMO).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

As a member of our plan you're eligible for a reduction in your Medicare Part B premium up to \$50 per month. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued. However, you'll receive a full credit of the premium reduction.

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A, if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

CHAPTER 1: Get started as a member

SECTION 6 Keep our plan member record up to date

Your member record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, and other providers in our plan's network **use your member record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second ("the secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

CHAPTER 1: Get started as a member

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

CHAPTER 2: Phone numbers and resources**SECTION 1 Generations Valor (HMO) contacts**

For help with at claims, billing, or member ID card questions, call or write to Generations Valor (HMO) Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). We'll be happy to help you.

Customer Care – Contact Information	
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30) Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
Fax	405-280-2960
Write	GlobalHealth, Inc. P.O. Box 1747 Oklahoma City, OK 73101
Website	www.globalhealth.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
TTY	711 Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)

CHAPTER 2: Phone numbers and resources

Coverage Decisions for Medical Care – Contact Information	
Fax	405-280-5398
Write	GlobalHealth, Inc. P.O. Box 2840 Oklahoma City, OK 73101
Website	www.globalhealth.com

Appeals for Medical Care – Contact Information	
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
TTY	711 Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
Fax	405-280-5294
Write	GlobalHealth, Inc. P.O. Box 2658 Oklahoma City, OK 73101
Website	www.globalhealth.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
TTY	711

CHAPTER 2: Phone numbers and resources

	Complaints about Medical Care – Contact Information
	Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
Fax	405-280-5294
Write	GlobalHealth P.O. Box 2658 Oklahoma City, OK 73101
Medicare website	To submit a complaint about Generations Valor (HMO) directly to Medicare, go to www.Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

	Payment Requests – Contact Information
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30).
TTY	711 Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30).
Fax	405-609-6354
Write	GlobalHealth P.O. Box 2718 Oklahoma City, OK 73101
Website	www.globalhealth.com

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

CHAPTER 2: Phone numbers and resources

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

	Medicare – Contact Information
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Generations Valor (HMO). To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

CHAPTER 2: Phone numbers and resources

SECTION 3 State Health Insurance Assistance Program(SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Oklahoma, the SHIP is called State Health Insurance Counseling Program.

State Health Insurance Counseling Program is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Counseling Program counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. State Health Insurance Counseling Program counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

	State Health Insurance Counseling Program (Oklahoma SHIP) – Contact Information
Call	1-800-763-2828
Write	State Health Insurance Counseling Program 400 NE 50th Street Oklahoma City, OK 73105
Website	https://www.oid.ok.gov/consumers/information-for-seniors/

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Oklahoma, the Quality Improvement Organization is called Acentra Health.

Acentra Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

Contact Acentra Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

CHAPTER 2: Phone numbers and resources

	Acentra Health (Oklahoma's Quality Improvement Organization) – Contact Information
Call	1-888-315-0636 Weekdays: 9 am - 5 pm Weekends and holidays: 10 am - 4 pm
TTY	711
Write	Acentra Health 5201 West Kennedy Blvd., Suite 900 Tampa, FL 33609
Website	https://www.acentraqio.com/

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

	Social Security– Contact Information
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

CHAPTER 2: Phone numbers and resources

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact SoonerCare (Medicaid).

	SoonerCare (Oklahoma's Medicaid program) – Contact Information
Call	1-800-987-7767 8 am - 5 pm, Monday through Friday
TTY	711
Write	SoonerCare Oklahoma Health Care Authority 4345 N Lincoln Blvd Oklahoma City, OK 73105
Website	https://oklahoma.gov/ohca/

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

	Railroad Retirement Board (RRB) – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

CHAPTER 2: Phone numbers and resources

	Railroad Retirement Board (RRB) – Contact Information
	Calls to this number aren't free.
WEBSITE	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

*Using our plan for your medical
services*

CHAPTER 3: Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Generations Valor (HMO) must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Generations Valor (HMO) will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 in this chapter for more information).
 - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3. You must see your assigned PCP for services. If your PCP is not available, you may see a PCP within the same PCP group. If no PCPs within the group are available, you may either change your assigned PCP or request prior authorization to see another PCP.

CHAPTER 3: Using our plan for your medical services

- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 3 *exceptions*:
 - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Get authorization from our plan prior to seeking care. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay our plan for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost-sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care**What is a PCP and what does the PCP do for you?**

When you become a member of our plan, you must choose a Primary Care Physician (PCP).

Your PCP will not only provide basic and routine services but may also coordinate other care you may need through referrals and prior authorizations. Your PCP may be a family practice, general practice, or internal medicine physician who participates in our network.

How to choose your PCP

You may choose a PCP from our *Provider Directory*, which can be found at <https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/medicare>, or contact Customer Care for help in selecting a PCP. You may only choose a PCP who is accepting new patients. If you do not choose a PCP when you enroll, one will be assigned to you. Seeing a network PCP who is not

CHAPTER 3: Using our plan for your medical services

your PCP of record or in the same physician group as your PCP of record will be treated as a specialist.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

To change your PCP, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). They'll check to be sure the PCP you want to switch to is accepting new patients. They'll send you a new member ID card that shows the name and phone number of your new PCP. You can also change your PCP by logging into your Member Portal. The Member Portal can be found at www.globalhealth.com. For help, call Customer Care. **The change will occur on the first day of the month following the date of the request.**

Be sure to tell Customer Care if you're seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). We'll help you make sure that you have the referrals and prior authorizations needed to continue with the services you've been getting when you change your PCP.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away
- Specialist office visits as long as you go to a network provider. The specialist will request prior approval for any tests or treatment such as specialized diagnostic tests, therapy, or outpatient surgery
- Preventive care as long as you get it from network providers
- Outpatient mental health and substance abuse individual or group therapy office visits as long as you get them from Carelon Behavioral Health network providers. The therapist will request prior approval for any tests or treatment

CHAPTER 3: Using our plan for your medical services

- Eye wear and routine eye exams as long as you get them from EyeMed network providers
- Hearing aids and hearing aid evaluations as long as you get them from NationsBenefits network providers
- Home support services as long as you get them from Papa Pals
- 24/7 nurse advice as long as you get it from Carenet Health
- Non-emergency transportation as long as you arrange it through RoundTrip
- Using your Smart Wallet Benefit as long as you use your card at the point-of-sale and follow the card rules. Go to the Smart Wallet Benefit description in Chapter 4, Medical Benefits Chart
- Supplemental preventive and comprehensive dental services as long as you get them from a DentaQuest network provider

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

Referrals

You'll usually see your PCP first for most of your routine health care needs. You may see any network specialist without a referral, but when your PCP or specialist believes you need specialized diagnostic tests or treatment (such as therapy or outpatient surgery), he/she will give you a referral for that care.

Prior authorization

Prior authorization from Generations Valor (HMO) is required before the appointment for almost all tests or treatment performed outside an office visit. When your doctor sends a referral to us, our team of nurses and physicians will review the referral. We'll notify your doctor and you of our decision. In most cases, services will be directed to in-network providers. If you do not have a prior authorization on record before you get services that require one, you may have to pay for those services yourself. Refer to Chapter 4, Medical Benefits Chart, for information about which services require prior authorization.

What if a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.

CHAPTER 3: Using our plan for your medical services

- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost-sharing. Prior authorization is required.
- If you find out your doctor or specialist is leaving our plan, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7).

Section 2.4 How to get care from out-of-network providers

In most cases, you must receive care from an in-network provider. Care you receive from an out-of-network provider won't be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, go to Section 3.
- If we authorize a referral to an out-of-network provider described in Section 2.3.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our service area. Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, worldwide, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Our phone number is on your member ID card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

CHAPTER 3: Using our plan for your medical services

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

You should always try to get urgently needed services from network provider. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

- If the need for urgent care occurs during your PCP's regular office hours, call your PCP for direction.
- If the need for urgent care occurs after hours or you cannot reach your PCP, go to an in-network urgent care facility listed in our *Provider Directory*. To find the most up-to-date *Provider Directory* please visit our website, <https://gh-findcare.globalhealthportals.com/oklahoma/globalhealth/medicare>.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- When you believe your situation to be an emergency and traveling or waiting until you are home would be unsafe for your medical condition.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit www.globalhealth.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Generations Valor (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached won't count toward an out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then you're only responsible for the in-network cost-sharing for the services in that trial. If you paid more - for example, if you already paid the Original Medicare cost-sharing amount - we'll reimburse the difference between what you paid and the in-network cost-sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that include require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

CHAPTER 3: Using our plan for your medical services

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost-sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care;
 - – *and* – You must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare inpatient hospital cost-sharing and coverage limits apply to services obtained in a religious non-medical health care institution. (Go to the Medical Benefits Chart in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members

CHAPTER 3: Using our plan for your medical services

to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Generations Valor (HMO), however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, Generations Valor (HMO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Generations Valor (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Generations Valor (HMO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$3,900.**

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **\$3,900**, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of Generations Valor (HMO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Generations Valor (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in bold. These services not listed in the Medical Benefits Chart also require prior authorization:
 - Referrals to any out-of-network providers.
 - Services which are covered benefits, but performed by the physician outside of his/her office.
 - Any other services not specifically listed in the Medical Benefits Chart.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	You pay a \$25 copayment for Medicare-covered acupuncture for chronic low back pain services. Referral and prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You pay 20% of the total cost for Medicare-covered air ambulance per one-way trip. You pay a \$240 copayment for Medicare-covered ground ambulance services per one-way trip. If you are admitted to the hospital, you do not have to pay the ambulance services coinsurance or copayment. You will be responsible for the cost if you call for an ambulance but do not go to the hospital. Non-transport services are not covered. Prior authorization is required for non-emergency transportation.
 Annual physical exam • Examination of the heart, lung, abdominal, and neurological systems • Hands-on examination of the body (such as head, neck, and extremities) • Detailed medical/family history • Limited to one exam per year in addition to the annual wellness visit Must be performed in your PCP office. Contact your PCP to set up an appointment.	There is no coinsurance, copayment, or deductible for annual physical exam.
 Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.	
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. Non-preventive medical services provided during the visit may require a copayment.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months • 2D and 3D mammograms	There is no coinsurance, copayment, or deductible for covered screening mammograms. Non-preventive medical services provided during the visit may require a copayment.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay a \$30 copayment per outpatient visit for Medicare-covered cardiac rehabilitation services or intensive cardiac rehabilitation services. Referral and prior authorization may be required.
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	Non-preventive medical services provided during the visit may require a copayment.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. Non-preventive medical services provided during the visit may require a copayment.
 Cervical and vaginal cancer screening Covered services include: - For all women: Pap tests and pelvic exams are covered once every 24 months - If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Must receive Pap tests and pelvic exams from your PCP or an in-network OB/GYN. Non-preventive medical services provided during the visit may require a copayment.
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation	You pay a \$20 copayment per visit for Medicare-covered chiropractic services.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. <u>Specialist services:</u> You pay a \$35 copayment per visit for Medicare-covered services in a specialist office visit.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	Referral and prior authorization may be required. <u>Remote Monitoring:</u> You pay a \$35 copayment once per 30 days for Medicare-covered remote monitoring services according to the coverage guidelines. <u>Care coordination and planning:</u> There is no coinsurance, copayment, or deductible for care coordination services.
Colorectal cancer diagnostic testing Tests to diagnose symptoms separate from screening services.	You pay a \$250 copayment per visit for Medicare-covered services in an ambulatory surgical center. Referral and prior authorization may be required. You pay a \$320 copayment per visit for Medicare-covered services in an outpatient surgery department. Referral and prior authorization may be required. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery, you do not have to pay the outpatient surgery or ambulatory surgery copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, there is no coinsurance, copayment, or deductible. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
- Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. - Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: - Dental services - comprehensive - Dental services - preventive	You pay a \$35 copayment per office visit for Medicare-covered dental services. Referral and prior authorization may be required.
*Dental services - comprehensive - Restorative services - Endodontics - Periodontics - Prosthodontics, removable - Maxillofacial prosthetics - Prosthodontics, fixed - Oral and maxillofacial surgery - Adjunctive general services For covered dental codes and specific limitations, go to the Dental Benefits table at the end of this section. If you have services before the timeframe ends, you'll be responsible	Restorative services: - There is no coinsurance, copayment, or deductible for fillings. - You pay 20% of the total cost for other restorative services. Endodontics: - You pay 20% of the total cost for endodontics. Periodontics:

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
for the cost of your services. For help finding a dentist in network or more information about these covered services, call DentaQuest at 1-833-955-3423 (TTY: 1-800-466-7566), 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30).	• There is no coinsurance, copayment, or deductible for periodontic cleanings. See Dental services - preventive. • You pay 20% of the total cost for other periodontics. Prosthodontics, removable • You pay 20% of the total cost for prosthodontics. Maxillofacial prosthetics • You pay 20% of the total cost for maxillofacial prosthetics. Prosthodontics, fixed • You pay 20% of the total cost for prosthodontics. Oral and maxillofacial surgery • You pay 20% of the total cost for oral and maxillofacial surgery. Adjunctive general services • There is no coinsurance, copayment, or deductible for adjunctive general services. We will only pay up to a total of \$1,500 for preventive and comprehensive dental services per year. You pay the amount that exceeds this allowance. *Coinsurance you pay for supplemental dental services does not count toward the

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	maximum out-of-pocket amount. Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount.
*Dental services - preventive • Cleaning • Dental x-ray(s) • Oral exam • Fluoride treatment For covered dental codes and specific limitations, go to the Dental Benefits table at the end of this section. If you have services before the timeframe ends, you'll be responsible for the cost of your services. For help finding a dentist in network or more information about these covered services, call DentaQuest at 1-833-955-3423 (TTY: 1-800-466-7566), 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30).	There is no coinsurance, copayment, or deductible for preventive dental services. There is no coinsurance, copayment, or deductible for periodontic cleaning, combined with preventive cleanings. We will only pay up to a total of \$1,500 for preventive and comprehensive dental services per year. You pay the amount that exceeds this allowance. *Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount.
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit. Non-preventive medical services provided during the visit may require a copayment.
Dermatology services We cover services and treatment routinely rendered in an office visit.	You pay a \$35 copayment per office visit for Medicare-covered dermatology services. Referral and prior authorization are not required for evaluation visits.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	Referral and prior authorization may be required for some services. There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. Non-preventive medical services provided during the visit may require a copayment.
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: - Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. - This is the only covered brand of blood glucose monitors and test strips: Ascensia (Contour). - These are the only covered brands of continuous glucose monitors (limited to 1 for 365 days) and supplies: Dexcom® and FreeStyle. - Generations Valor (HMO) covers any blood glucose monitors and test strips specified within the preferred brand list above through network pharmacies.	There is no coinsurance, copayment, or deductible for Medicare-covered standard diabetic testing supplies. Prior authorization may be required. There is no coinsurance, copayment, or deductible for Medicare-covered therapeutic shoes or inserts. Prior authorization may be required. There is no coinsurance, copayment, or deductible for Medicare-covered diabetes self-management training.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
◦ Generally, Generations Valor (HMO) covers any blood glucose monitors and test strips specified within the preferred brand list above through network pharmacies. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to Generations Valor (HMO) and using a brand of blood glucose monitor and test strips not on our list, we'll continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand of blood glucose monitor and test strips is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) • If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, go to Chapter 7.) • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	Non-preventive medical services provided during the visit may require a copayment.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a	You pay 20% of the total cost for Medicare-covered durable medical equipment. Prior authorization may be required. There is no coinsurance, copayment, or deductible for Part B diabetic supplies. See Diabetic self-management

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.globalhealth.com.	training, diabetic services and supplies for more information. Prior authorization may be required. Your cost-sharing for Medicare oxygen equipment coverage is 20% of the total cost every month. After 36 months of being enrolled in Generations Valor (HMO), your cost share will change to \$0 for concentrators. If you use oxygen tanks or cylinders that need delivery of oxygen content, you will pay 20% of the Medicare-approved amount. Prior authorization may be required. There is no coinsurance, copayment, or deductible for Medicare-covered durable medical equipment provided by your home health agency. Prior authorization may be required.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, (and, if you're a pregnant woman, loss of an unborn child),	You pay a \$90 copayment per visit for all Medicare-covered emergency care services received during the visit. If you are admitted to the hospital as inpatient or to outpatient observation within 24 hours for the same condition, you do not have to pay the emergency care copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care is covered within the U.S. and its territories.	If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copayment. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost you would pay at a network hospital.
*Emergency care - worldwide coverage • This includes emergency or urgently needed care • Ambulance services are not covered • Transportation back to the United States from another country is not covered • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition if provided by a non-qualified provider) and/or elective procedures are not covered • Services provided by a dentist are not covered GlobalHealth will not reimburse you for your copayment responsibility paid at the time of service. GlobalHealth will reimburse you for additional covered costs you pay related to the emergency or urgent care services. If you need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.	You pay a \$90 copayment per visit for emergency services outside the United States and its territories. You are covered for up to \$50,000 every year for emergency or urgently needed services (combined) outside the United States. *Copayments you pay for worldwide emergency services do not count toward the maximum out-of-pocket amount. Any amount you pay above the plan limitation does not count toward the maximum out-of-pocket amount.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Health and wellness education programs Members have access to fitness centers along with support staff including: • Fitness instructors and fitness advisors at the fitness centers • On-demand home fitness video library • Choice of wearable wireless fitness tracker options • Online classes • Healthy aging education classes • A mobile app The goal of the benefit is to encourage members to lose weight, reduce falls, and get/stay healthier. There is no referral or preauthorization required for fitness benefits. For more information, no-cost registration, or finding gym locations, go to www.GlobalHealth.com .	There is no coinsurance, copayment, or deductible for an annual membership. Any amount you pay for a personal fitness trainer or for fitness centers outside the standard fitness center network does not count toward the maximum out-of-pocket amount.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	There is no coinsurance, copayment, or deductible for Medicare-covered PCP diagnostic hearing and balance evaluations. You pay a \$35 copayment per visit for specialist exams to diagnose and treat hearing and balance issues.
*Hearing services - Hearing aids • Hearing aids • Hearing aid fitting and evaluation limited to 1 every year *Hearing aid purchases include: • 3 follow-up visits within first year of initial fitting date • 60-day trial period from date of fitting • 60 batteries per year per aid (3-year supply) • 3-year manufacturer repair warranty • 1-time replacement coverage for lost, stolen or damaged hearing aid (deductible may apply per aid)	There is no coinsurance, copayment, or deductible for hearing aids and services. We will only pay up to a total of \$1,000 for hearing aid devices per year for both ears combined. You pay the amount that exceeds this allowance. *Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
NationsBenefits offers a wide selection of hearing aids from all major manufacturers. Please call 1-877-241-4736 (TTY: 711) to learn more about your hearing aid benefit 8 am to 8 pm, 7 days a week.	
Hearing services - Routine hearing evaluations Limited to 1 evaluation to determine the need for hearing aids every year Please contact NationsBenefits at 1-877-241-4736 (TTY: 711) to schedule an appointment 8 am to 8 pm, 7 days a week.	There is no coinsurance, copayment, or deductible for a hearing aid evaluation. You must obtain your hearing aid evaluation, hearing aids, and fitting from a NationsBenefits provider. Other hearing services are not covered during this evaluation.
Hearing services - Routine hearing exam Limited to 1 exam every year.	There is no coinsurance, copayment, or deductible for routine hearing exam. You must obtain your routine hearing exam from a GlobalHealth provider. Non-routine medical services provided during the visit may require a copayment.
 HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: - One screening exam every 12 months If you are pregnant, we cover: - Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. Non-preventive medical services provided during the visit may require a copayment.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to:	There is no coinsurance, copayment, or deductible for Medicare-covered home health visits. Referral and prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	There is no cost-sharing for home health care services and items provided by a home health agency. However, the applicable cost-sharing listed elsewhere in the Medical Benefits Chart will apply if the item is not provided by a home health agency. Prior authorization may be required.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	There is no coinsurance, copayment, or deductible for Medicare-covered professional services, including nursing services, training and education, remote monitoring and monitoring services. Referral and prior authorization may be required. You pay up to 20% of the total cost for Medicare Part B covered drugs. May be subject to step therapy. See Medicare Part B prescription drugs. Prior authorization may be required.
*Home support services (Papa Pals) Covered services include: • Light house tasks such as meal prep, organization, laundry • Tech help such as setting up personal phones or computers, assisting with telehealth appointments • Transportation to and from doctor appointments, grocery shopping, or other errands	There is no coinsurance, copayment, or deductible for home support services. *Any amount you pay for home support visits beyond the hour limitation does not count toward the maximum out-of-pocket amount.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Virtual visits via phone Papa Pal services are provided for up to 30 hours per year, with a minimum of one hour per visit. Visits are available seven days a week, between 8 am and 7 pm local time, except for Thanksgiving, Christmas, and New Years Day. To schedule services please call 1-855-485-9692 (TTY: 711) 8 am - 10 pm, 7 days a week. Initial call will include an assessment to help match your "Papa Pal" based on interests and needs. 72 hours in advance to schedule a visit may be required. Papa Pals undergo background checks, motor vehicle record checks, and participate in ongoing training and education. Papa Pals are not certified to support Activities of Daily Living such as feeding, toileting, or dressing.	
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: - Drugs for symptom control and pain relief - Short-term respite care - Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Generations Valor (HMO). There is no coinsurance, copayment, or deductible for hospice consultation services.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost-sharing. For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare For services covered by Generations Valor (HMO) but not covered by Medicare Part A or B: Generations Valor (HMO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Other vaccines if you're at risk and they meet Medicare Part B coverage rules	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Our plan covers up to 190 days for an inpatient hospital stay per admission. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 190 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 190 days. Covered services include but aren't limited to: - Semi-private room (or a private room if medically necessary) - Meals including special diets - Regular nursing services - Costs of special care units (such as intensive care or coronary care units) - Drugs and medications - Lab tests - X-rays and other radiology services - Necessary surgical and medical supplies - Use of appliances, such as wheelchairs - Operating and recovery room costs - Physical, occupational, and speech language therapy - Inpatient substance abuse services	For each Medicare-covered hospital stay: - You pay a \$295 copayment per day for days 1 through 7. - There is no coinsurance, copayment, or deductible for days 8 through 90. - There is no coinsurance, copayment, or deductible for days 91 through 190. Cost-sharing is charged for each inpatient stay. Hospital copayments apply on the date of admission. Note: If you are admitted to the hospital in 2025 and are not discharged until sometime in 2026, the 2025 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility. Referral and prior authorization may be required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Generations Valor (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. - Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need - Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Our plan covers up to 90 days for an inpatient hospital stay per admission. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer	For each Medicare-covered hospital stay: - You pay a \$295 copayment per day for days 1 through 7. - There is no coinsurance, copayment, or deductible for days 8 through 90.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per admission.	Cost-sharing is charged for each inpatient stay. Hospital copayments apply on the date of admission. Note: If you are admitted to the hospital in 2025 and are not discharged until sometime in 2026, the 2025 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility. Referral and prior authorization may be required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services	You pay the same copayments or coinsurances for services as listed elsewhere in this benefit chart. You pay 100% of facility charges for a non-covered inpatient hospital or SNF stay. Your applicable outpatient services copayment or coinsurance applies to the Medicare-covered services and supplies you receive during a

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	non-covered hospital or SNF stay. See outpatient services elsewhere in this chart for your costs. Referral and prior authorization may be required.
*Meal benefit We cover meals for members discharged from an inpatient facility (Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation). Outpatient stays in a hospital do not count – you must be admitted as an inpatient (if you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff). Limited to 2 meals per day for 5 days, for a total of 10 meals for each discharge, up to 4 times (discharges) per year.	There is no coinsurance, copayment, or deductible for the meal benefit. Prior authorization may be required.
 Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Non-preventive medical services provided during the visit may require a copayment.
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs.	You pay up to 20% of the total cost for Medicare Part B covered drugs. Prior authorization may be required. For chemotherapy/radiation: You pay up to 20% of the total cost for Medicare Part B covered drugs. Prior authorization may be required. You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service. This applies to specific Part B drugs and may include chemotherapy drugs. For insulin: You pay up to 20% of the total cost. You will pay no more than \$35 for a one-month's supply of Part B insulin. This applies to insulin used in an insulin pump.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding)	Prior authorization may be required. For Medicare-covered Part B drugs obtained at a network pharmacy, coinsurance is applied to the health plan's actual cost, which reflects the pharmacy benefit manager's pricing and dispensing fee. Both the pricing and dispensing fee vary by drug and by brand versus generic. It can also vary by the type of dispensing pharmacy (e.g., long term care versus retail). For Medicare-covered Part B drugs obtained from a physician, the coinsurance is applied to the Medicare fee schedule.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
The listed drugs may be subject to Step Therapy. This link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.globalhealth.com/oklahoma/pharmacy/drug-formularies. We also cover some vaccines under our Part B drug benefit.	
Nurse line A nursing professional is standing by 24/7. Members may call when they have questions about health-related issues such as symptoms they are having or whether they should see a doctor or go to a hospital. Call 1-800-554-9371 (TTY: 711), 24 hours a day, seven days a week.	There is no coinsurance, copayment, or deductible for nurse line calls.
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. Non-preventive medical services provided during the visit may require a copayment.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	There is no coinsurance, copayment, or deductible for Medicare-covered certified opioid treatment program services. Referral and prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
For help finding a certified opioid treatment program, contact Carelon Behavioral Health at 1-888-434-9202 (TTY: 711), 7 am - 5 pm, Monday - Friday.	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests	Note: If a member receives multiple services (except medical supplies or blood) at the same location on the same day, only the maximum copay applies. There is no coinsurance, copayment, or deductible for Medicare-covered x-rays. You pay a \$50 copayment per visit for Medicare-covered therapeutic radiology services. Referral and prior authorization may be required. You pay 20% of the total cost for Medicare-covered prosthetic devices and related supplies, splints, casts, and other devices. Prior authorization may be required. You pay a \$5 copayment for Medicare-covered laboratory tests. There is no coinsurance copayment, or deductible for Medicare-covered blood. Referral and prior authorization may be required. There is no coinsurance, copayment, or deductible for simple Medicare-covered

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	outpatient diagnostic tests such as ultrasound, electrocardiogram (ECG or EKG), electroencephalogram (EEG), mammogram, or treadmill stress test. Referral and prior authorization may be required. There is no coinsurance, copayment, or deductible for sleep studies in your home. Referral and prior authorization may be required. You pay a \$100 copayment per visit for sleep studies in an outpatient facility setting. Referral and prior authorization may be required. You pay a \$180 copayment per visit for complex Medicare-covered outpatient diagnostic tests such as MRI, CT, PET, electromyography, or nuclear stress test in a PCP or specialist office setting, urgent care facility, or a preferred (non-hospital based) radiological facility. Referral and prior authorization may be required except in PCP office. You pay a \$250 copayment per visit for complex Medicare-covered outpatient diagnostic tests such as MRI,

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	CT, PET, electromyography, or nuclear stress test in a non-preferred (hospital based) radiological facility. Referral and prior authorization may be required.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at https://medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	You pay a \$300 copayment per visit for Medicare-covered observation services. If you are admitted to the inpatient acute level of care from observation, you do not have to pay the observation services copayment and the inpatient acute cost-sharing applies. Referral and prior authorization may be required.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	You pay a \$90 copayment per visit for all Medicare-covered emergency care services received during the visit. If you are admitted to the hospital as inpatient or to outpatient observation within 24 hours for the same condition, you do not have to

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	pay the emergency care copayment. If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copayment. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital. You pay a copay of \$300 copayment per visit for Medicare-covered observation services. If you are admitted to the inpatient acute level of care from observation, you do not have to pay copayment for observation and the inpatient acute cost-sharing applies. Referral and prior authorization may be required. You pay a \$320 copayment per visit for Medicare-covered outpatient surgery services. If you are admitted to the inpatient acute level of care

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	from outpatient surgery, you do not have to pay copayment for outpatient surgery and the inpatient acute cost-sharing applies.
	Referral and prior authorization may be required.
	You pay a \$5/visit copayment for Medicare-covered laboratory tests.
	You pay a \$55 copayment per visit for Medicare-covered partial hospitalization program services.
	Referral and prior authorization may be required.
	There is no coinsurance, copayment, or deductible for x-rays.
	You pay a \$180 copayment per visit for complex Medicare-covered outpatient diagnostic tests such as MRI, CT, PET, electromyography, or nuclear stress test in a PCP or specialist office setting, urgent care facility, or a preferred (non-hospital based) radiological facility.
	Referral and prior authorization may be required except in PCP office.
	You pay a \$250 copayment per visit for complex Medicare-covered outpatient diagnostic tests such as MRI,

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	CT, PET, electromyography, or nuclear stress test in a non-preferred (hospital based) radiological facility. Referral and prior authorization may be required. You pay a 20% coinsurance for Medicare-covered prosthetic devices and medical supplies. You pay up to 20% of the total cost for Medicare Part B drugs. May be subject to step therapy. See Medicare Part B drugs. Prior authorization may be required. You pay a \$35 copayment per visit for Medicare-covered hyperbaric oxygen therapy services. Referral and prior authorization may be required. You pay a \$15 copayment per visit for Medicare-covered wound care. Referral and prior authorization may be required.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or	There is no coinsurance, copayment, or deductible for Medicare-covered individual or group sessions. Referral and prior authorization are not required for evaluation and counseling visits.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
other Medicare-qualified mental health care professional as allowed under applicable state laws.	Referral and prior authorization may be required for some services.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay a \$20 copayment per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy. Referral and prior authorization may be required. There is no coinsurance, copayment, or deductible for Medicare-covered services provided in your home through a home health agency. Referral and prior authorization may be required.
Outpatient substance use disorder services Covered services include individual and/or group chemical dependency counseling sessions and telehealth services provided by a state-licensed clinical psychologist, psychiatrist, doctor, clinical social worker, clinical nurse specialist, physician assistant, or other Medicare qualified substance use disorder health care professional as allowed under applicable state laws. Medication management and therapy services provided by a state-licensed psychiatrist or doctor.	There is no coinsurance, copayment, or deductible for Medicare-covered individual or group sessions. Referral and prior authorization are not required for evaluation and counseling visits. Referral and prior authorization may be required for some services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're	You pay a \$250 copayment per visit for Medicare-covered services in an ambulatory surgical center. Referral and prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	You pay a \$320 copayment per visit for Medicare-covered services in an outpatient surgery department. Referral and prior authorization may be required. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery, you do not have to pay the outpatient surgery or ambulatory surgery copayment and the inpatient acute cost-sharing applies.
Partial hospitalization services and Intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	You pay a \$55 copayment per visit for Medicare-covered partial hospitalization program services or intensive outpatient services. Referral and prior authorization may be required.
*Personal Emergency Response System • A personal emergency response system device • 24/7 monitoring services	There is no coinsurance, copayment, or deductible for a personal emergency

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Please contact NationsBenefits at 1-877-241-4736 (TTY: 711), 8 am to 8 pm, 7 days a week to get started.	response system device or monitoring service.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: preventive screening, consultation, diagnosis, and treatment by your PCP ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Call your PCP to set up a telehealth appointment. Your PCP may provide services online or via phone. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:	<u>PCP office visits:</u> There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. There is no coinsurance, copayment, or deductible for Medicare-covered primary care physician services during a telehealth visit. There is no coinsurance, copayment, or deductible to see a physician assistant, nurse practitioner, or other provider in your PCP's office. There is no coinsurance, copayment, or deductible for telehealth services. <u>Specialist services:</u> <u>Office visits</u> You pay a \$35 copayment per visit for Medicare-covered specialist services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. Referral and prior authorization are not required for evaluation visits. Referral and prior authorization may be required for some services.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ◦ You're not a new patient and ◦ The check-in isn't related to an office visit in the past 7 days and ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ◦ You're not a new patient and ◦ The evaluation isn't related to an office visit in the past 7 days and ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery	You pay a \$35 copayment per visit to see a physician assistant, nurse practitioner, or other provider in a specialist's office. Referral and prior authorization are not required for evaluation visits. Referral and prior authorization may be required for some services. Visits at other locations during Medicare-covered stays are included in the cost-sharing for those services. Referral and prior authorization may be required. <u>Remote Monitoring</u> You pay a \$35 copayment once per 30 days for Medicare-covered remote monitoring services according to the coverage guidelines. Prior authorization may be required. <u>Telehealth</u> You pay a \$35 copayment per visit for Medicare-covered specialist services during a Medicare-covered telehealth visit. You pay a \$35 copayment per visit to see a physician assistant, nurse practitioner, or other provider in a specialist's office.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	<u>Preventive care office visits</u> A preventive care service will not have a copayment. However, if you are treated or monitored for an existing medical condition during the same visit, cost-sharing will apply. <u>Specialized outpatient diagnostic tests</u> You pay a separate \$180 copayment for outpatient diagnostic tests, including but not limited to magnetic resonance imaging (MRI), computed tomography (CT), electromyography, nuclear stress test, and positron emission tomography (PET). Referral and prior authorization may be required in specialist office. <u>Part B drugs</u> You pay up to 20% of the total cost for Medicare Part B covered drugs. May be subject to step therapy. See Medicare Part B drugs. Prior authorization may be required.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	You pay a \$35 copayment per office visit for Medicare-covered podiatry services. Referral and prior authorization are not required for evaluation visits.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	Referral and prior authorization may be required for some services. There is no coinsurance, copayment, or deductible for the PrEP benefit. Non-preventive medical services provided during the visit may require a copayment.
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. You must receive your prostate cancer screening from your PCP. Non-preventive medical services provided during the visit may require a copayment.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic	You pay 20% of the total cost for Medicare-covered prosthetic devices and related medical supplies. Prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay a \$15 copayment per outpatient visit for Medicare-covered pulmonary rehabilitation services. Referral and prior authorization may be required.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. Non-preventive medical services provided during the visit may require a copayment.
 Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. Non-preventive medical services provided during the visit may require a copayment.
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Non-preventive medical services provided during the visit may require a copayment.
Services to treat kidney disease Covered services include:	There is no coinsurance, copayment, or deductible for Medicare-covered kidney

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, please go to the section, Medicare Part B drugs in this table.	disease education services including self-dialysis training. You pay 20% of the total cost for each Medicare-covered renal dialysis treatment in an outpatient facility. Referral and prior authorization may be required. No additional charge for dialysis treatment as an inpatient. Refer to "Inpatient hospital care" in this Medical Benefits Chart for cost share. Referral and prior authorization may be required. You pay the home health agency care cost share for home dialysis equipment if provided by a home health agency. Otherwise, you pay the durable medical equipment cost share. Referral and prior authorization may be required. There is no coinsurance, copayment, or deductible for Medicare-covered self-dialysis or home support services. Referral and prior authorization may be required. You pay up to 20% of the total cost for Medicare Part B covered drugs.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
	May be subject to step therapy. See Medicare Part B prescription drugs. Prior authorization may be required.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Our plan covers up to 100 days per benefit period. Prior hospital stay is not required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	For Medicare-covered skilled nursing facility stays per benefit period: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a \$218 copayment per day for days 21 through 100. A benefit period begins the day you are admitted to inpatient care or SNF and ends when you haven't received any care as an inpatient or in a SNF for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Referral and prior authorization may be required.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
*Smart Wallet Benefit A Benefits Mastercard® Prepaid Benefits Card, through our partnership with NationsBenefits. • Smart Wallet Benefit amount is loaded each new quarter; unused portion doesn't carry over to the next quarter • Funds are not available until accrued • Benefits must be used during the calendar year • You must first attempt to use your Smart Wallet Benefit card at the point-of-sale for approved items at an approved location • Reimbursements are only eligible when: ◦ The Smart Wallet Benefit card was first attempted at the point-of-sale for approved items in a retail setting ◦ The transaction failed due to a technical issue not related to insufficient funds ◦ GlobalHealth/NationsBenefits must be able to verify that the card was used, or an attempt was made to use it, prior to any out-of-pocket payment method being utilized ◦ Submit itemized receipts for consideration ◦ Reimbursement will not be provided for amounts that exceed your available Smart Wallet Benefit balance at the time of the purchase • Combined benefit amount for dental, hearing, and vision services and devices as well as over-the-counter items and products • <u>Dental, hearing, and vision:</u> ◦ Separate from other benefits for these services or devices listed elsewhere in this Medical Benefits Chart	There is no coinsurance, copayment, or deductible for your Smart Wallet Benefit. We will only pay up to a total of \$100 per quarter for a combination of over-the-counter items, products, dental, hearing, and/or vision services and devices. You pay the amount that exceeds this benefit. *Any amount you pay above the plan benefit amount does not count toward the maximum out-of-pocket amount.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
◦ May be used for any services or devices, including non-covered items like dental implants or prescription sunglasses, or for office copayments or service coinsurance ◦ May be used at any location designated to provide these services or devices, such as dental, vision, or hearing offices or eyewear stores • <u>Over-the-counter including nicotine replacement therapy:</u> ◦ Spend on over-the-counter health and wellness products through the catalog or at certain retail stores, including nicotine replacement therapy; visit the Member Portal at www.globalhealth.com for a list of locations ◦ Items include allergy relief medications, pain relievers, first aid items, blood pressure cuffs, vitamins and minerals, and many other items; restrictions apply The benefit cannot be used for cash withdrawal nor purchase the following services or products: cosmetic procedures, hospital indemnity insurance, funeral planning and expenses, life insurance, alcohol, tobacco, cannabis products, broad membership programs inclusive of multiple unrelated services and discounts, and non-healthy food. For more information, see our website at www.globalhealth.com. Call NationsBenefits with questions about locations or a transaction at 1-877-241-4736 (TTY: 711), 8 am to 8 pm, 7 days a week.	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	You pay a \$25 copayment per outpatient visit for Medicare-covered SET services. Referral and prior authorization may be required.
*Transportation Non-emergency ground transportation to a plan-approved health-related location in order to obtain care and services under the plan's benefits. • Plan-approved locations limited to: ◦ Doctor office visits ◦ Lab appointments ◦ Chemo/radiation/dialysis appointments ◦ Outpatient hospital visits ◦ Outpatient preventive services appointments ◦ Pharmacy	There is no coinsurance, copayment, or deductible. *Any amount you pay for rides beyond the trip or location limitation does not count toward the maximum out-of-pocket amount.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
• Trips are limited to 24 one-way trips per year – a round-trip counts as 2 one-way trips • Trips are limited to 50 miles per one-way trip • 48 hours in advance to schedule routine trips may be required One companion is allowed per trip (companion must be at least 18 years old) For more information about plan-approved locations, please call Customer Care. To request a ride, call RoundTrip at 1-877-565-1612 (TTY: 711).	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services are covered within the U.S. and its territories.	<u>Urgent care visits:</u> You pay a \$15 copayment per visit for Medicare-covered urgently needed services, except specialized diagnostic tests, during the visit. <u>Specialized diagnostic tests:</u> You pay a \$180 copayment for outpatient diagnostic tests, including but not limited to magnetic resonance imaging (MRI), computer tomography (CT), and positron emission tomography (PET).
*Urgently needed services - worldwide coverage • This includes emergency or urgently needed care • Ambulance services are not covered • Transportation back to the United States from another country is not covered • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition if provided by a non-qualified provider) and/or elective procedures are not covered • Services provided by a dentist are not covered	You pay a \$90 copayment per visit for urgently needed services outside the United States and its territories. You are covered for up to \$50,000 every year for emergency or urgently needed services (combined) outside the United States. *Copayments you pay for worldwide urgently needed

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
 Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. You must use EyeMed providers to get your eyeglasses or contact lenses after cataract surgery. You must use a GlobalHealth network provider for all other services.	care services do not count toward the maximum out-of-pocket amount. Any amount you pay above the plan limitation does not count toward the maximum out-of-pocket amount. There is no coinsurance, copayment, or deductible for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. There is no coinsurance, copayment, or deductible for Medicare-covered screenings. There is no coinsurance, copayment, or deductible for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. Eyeglasses may be lenses only, frames only, or full pair (frames and lenses). You must obtain your eyewear from an EyeMed provider.
Vision care - supplemental eye exams and eyewear • One supplemental routine eye exam per year to be fitted for eyeglasses <u>or</u> contact lenses. • *Eyeglasses and contact lenses: ◦ Pair (frames and lenses) ◦ Lenses only ◦ Frames only	There is no coinsurance, copayment, or deductible for one supplemental eye exam per year. There is no coinsurance, copayment, or deductible for supplemental eyewear.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay
Fitting for either eyeglasses <u>or</u> for contact lenses Note: Upgrades, such as tinting or progressive lenses, are not covered. You must use EyeMed providers for these services.	We will only pay up to a total of \$300 for supplemental eye wear per year. If the eye wear you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. *Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount.
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.	There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your <i>Welcome to Medicare</i> preventive visit. Non-preventive medical services provided during the visit may require a copayment.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)**Mandatory Supplemental Dental Benefits****Annual Maximum Allowance: \$1,500**

After the annual allowance maximum is exhausted, any remaining charges are your responsibility.

When multiple codes are listed together with a limitation, all codes are subject to the one limitation.

A specialty dentist may require referral from your general dentist.

Services that are covered for you	What you must pay when you get these services
Bridges, Crowns, Inlays, and Onlays • D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792 or D2794 limited to once • D2910, D2915, or D2920 limited to once per tooth per date of service only after 6 months of initial placement • D2931 limited to once per tooth per date of service • D2940 limited to once per tooth per lifetime • D2950, D2951, D2952, D2953, or D2954 once per tooth per date of service • D2980 limited to once per tooth per date of service only after 6 months of initial placement • D2999	20%
Cleanings – Standard and Periodontal • D1110, D4346, or D4910 limited to two every 12 months • D4910 limited to four every 12 months (following active therapy)	\$0
Consultation • D9310 limited to once per date of service	\$0

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Dentures – Complete Dentures, Adjustments and Repairs • D5110, D5130, D5211, D5213, D5221, D5223, D5225, D5227, D5282, D5863, or D5864 limited to once per date of service • D5120, D5140, D5212, D5214, D5222, D5224, D5226, D5228, D5283, D5865, or D5866 limited to once per date of service • D5284 limited to once per date of service • D5286 limited to once per date of service • D5410, D5411, D5421, D5422 limited to two adjustments per arch per date of service only after 6 months of initial placement • D5511, D5512, D5520 limited to once per arch per date of service • D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5670, D5671 limited to once per arch per date of service only after 6 months of initial placement • D5710, D5730, or D5750 limited to once per date of service after 6 months of initial placement • D5711, D5731, or D5751 limited to once per date of service after 6 months of initial placement • D5720, D5740, D5760 limited to once per date of service after 6 months of initial placement • D5725 limited to one per arch per date of service after 6 months of initial placement • D5721, D5741 or D5761 limited to once per date of service after 6 months of initial placement • D5765 limited to once per arch per date of service after 6 months of initial placement • D5810, D5811, D5820, D5821 limited to once per date of service • D5850 or D5851 limited to in conjunction with new denture or after 60 months of delivery of new denture • D5876, D5899, D5999	20%
Endodontic Services – Root Canals • D3110 or D3120 limited to once per tooth per lifetime • D3220 or D3221 limited to once per tooth per lifetime • D3310, D3320, D3330, D3331, D3346, D3347, D3348, D3410, D3421, D3425, D3426, D3430 limited to once per tooth per lifetime • D3999	20%

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Exams – Routine and Comprehensive • D0120, D0160, or D0170 limited to two every 12 months • D0150 or D0180 limited to two every 12 months • D0140 is limited to two every 12 months	\$0
Extractions • D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, or D7251 limited to once per tooth per lifetime	\$0
Fillings • D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, or D2990 limited to one restoration per tooth, per surface, once in 24 months	\$0
Fluoride treatments • D1206 or D1208 limited to two every 12 months	\$0
Miscellaneous Services • D9910 limited to two per 12 months • D9911 limited to once per tooth per date of service • D9930 limited to once per year • D9932, D9935 • D9950 or D9952 limited to one per 60 months • D9951 limited to one per 12 months • D9999	20%
Nitrous Oxide and Sedation • D9211, D9215, D9222, D9230, D9239, or D9248 limited to one per date of service • D9223 or D9243 limited to 3 per date of service	\$0

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Oral Surgery • D7260, D7261 limited to two per arch per lifetime • D7284, D7285, D7286 • D7310 or D7311 limited to once per quadrant per lifetime • D7320 or D7321 limited to once per quadrant per lifetime • D7340, D7350 limited to once per arch per lifetime • D7410, D7411, D7440, D7441, D7450, D7451, D7460, D7461 • D7471 limited to two per arch per lifetime • D7472 limited to once per lifetime • D7485, D7473 limited to two per lifetime • D7510, D7520, D7521 • D7511, D7630, D7953 • D7961 or D7963 limited to once per arch per lifetime • D7962 limited to once per arch per lifetime • D7970 limited to once per arch per lifetime • D7971 limited to once per tooth per lifetime • D7999	20%
Other Periodontic Services – Periodontal Scaling and Root Planing; Full Mouth Debridement • D4210, D4211, D4240, D4241, D4260, or D4261 limited to once per quadrant per date of service • D4212 limited to once per date of service • D4249 limited to one per tooth per lifetime • D4341 or D4342 limited to once per quadrant per date of service • D4355 limited to one per 36 months • D4999	20%
Other Restorative Services - Recementing, Crown Preparation, Veneers, Repairs • D2915, D2920 limited to once per tooth per date of service after 6 months of initial placement • D2940 limited to once per tooth per lifetime • D2950 limited to once per tooth per date of service	20%
Palliative Treatment • D9110	\$0

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Partials - Fixed • D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, or D6252 limited to once per tooth per date of service • D6253 limited to once per date of service • D6545, D6548, D6549, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6793, or D6794 limited to once per tooth per date of service • D6920, D6930, D6940, D6980, limited to once per date of service • D6999	20%
Partials – Removal Partial Dentures, Adjustments and Repairs • D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5227, D5228 limited to once per date of service • D5421, D5422 limited to once per arch per date of service after 6 months of initial placement • D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660 limited to once per arch per date of service • D5720, D5721, D5725, D5740, D5741, D5760, D5761, D5765, D6930 limited to once per date of service after 6 months of initial placement	20%
Professional Visits • D9410, D9420 limited to once per date of service	
Teledentistry • D9995 or D9996 limited to once per date of service	\$0

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services that are covered for you	What you must pay when you get these services
X-rays and Diagnostics – Bitewing, Panoramic, CT, Cephalograms, MRI • D0210, D0277, D0330, or D0372 limited to one every 36 months • D0220 limited to one per date of service • D0230 limited to one per date of service • D0240 limited to two every 24 months • D0270, D0272, D0273, D0274, or D0373 limited to one every 12 months • D0374 limited to one every 12 months	\$0

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing	Not covered under any condition

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care Some non-routine dental care may be covered under our comprehensive dental benefit
Orthopedic shoes or supportive device for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Some routine eye care may be covered under our supplemental vision benefit.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

*Asking us to pay our share of a bill
for covered medical services*

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing as discussed in this material. First try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. When you've got emergency or urgently needed medical care from a provider who's not in our plan's network

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

CHAPTER 5: Asking us to pay our share of a bill for covered medical services

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called **balance billing**. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 60 days** of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster. Required information includes member name, member ID number, contact information, provider name and contact information, item or service, and date of service.
- Download a copy of the form from our website (www.globalhealth.com) or call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

GlobalHealth, Inc.
P.O. Box 2718

Oklahoma City, OK 73101

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

CHAPTER 6: Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with GlobalHealth Section 1557 Coordinator, P.O. Box 2658, Oklahoma City, OK 73101-2658, Phone: 1-844-280-5555 (TTY: 711), Fax: 1-405-280-5294; Email: section1557coordinator@globalhealth.com. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) or other providers listed in Chapter 3 Section 2.2 without a referral.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

CHAPTER 6: Your rights and responsibilities

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7, tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).

GlobalHealth Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CHAPTER 6: Your rights and responsibilities

GlobalHealth is committed and required to protect the privacy and confidentiality of our Members' Protected Health Information ("PHI") in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act. This HIPAA Notice of Privacy Practices (the "Notice") contains important information regarding your PHI. Our current Notice is posted at www.globalhealth.com.

How GlobalHealth May Use or Disclose Your Health Information

For Treatment. We may use and/or disclose your PHI to a healthcare provider, hospital, or other healthcare facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Plan Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc. We will not use or disclose your genetic information for underwriting purposes.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, providers, or care settings.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information:

- To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting.
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process.
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process.
- To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability.
- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services ("CMS"), State Department of Health, Insurance Department, etc.
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations.
- In order to comply with laws and regulations related to Workers' Compensation.
- For coordination of insurance or Medicare benefits, if applicable.

CHAPTER 6: Your rights and responsibilities

- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and
- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative.

Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary, in an emergency if the use or disclosure is necessary for your emergency treatment.

Military/Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a “limited data set,” we may give that information to others for purposes of research, public health action or health care operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Other Uses. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner.

NOTE: We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale

CHAPTER 6: Your rights and responsibilities

of PHI require your written authorization. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

Your Health Information Rights**Right to Inspect and Copy**

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If we agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the

CHAPTER 6: Your rights and responsibilities

amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

Right to Revoke Authorization

You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

Changes to this Notice

GlobalHealth is required to comply with the requirements of this Notice currently in effect. We reserve the right to change this Notice and make the new provisions effective for all PHI that we maintain. The revised Notice will be made available to you on our website at www.globalhealth.com.

To Report a Privacy Violation

If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at:

ATTN: Privacy Officer
210 Park Avenue
Suite 2900
Oklahoma City, OK 73102
Toll-free 1-877-627-0004
Email privacy@globalhealth.com

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. We will not penalize nor retaliate against you for filing a complaint with the Secretary of DHHS, or with GlobalHealth.

GlobalHealth provides free aids and services to people with disabilities to communicate effectively with us, such as (a) qualified sign language interpreters; (b) written information in other formats (large print, audio, accessible electronic formats, other formats), (c) qualified

CHAPTER 6: Your rights and responsibilities

interpreters; (d) information written in other languages . If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free) (TTY:711).

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: Medicare Compliance Officer
210 Park Ave
Suite 2900
Oklahoma City, OK 73102-5621
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 20201
[1-800-368-1019](tel:1-800-368-1019), [800-537-7697](tel:800-537-7697) (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Please be advised that most Third-Party App's will not be covered by HIPAA. Most apps will instead fall under the jurisdiction of the Federal Trade Commission (FTC) and the protections provided by the FTC Act. The FTC Act, among other things, protects against deceptive acts (e.g., if an app shares personal data without permission, despite having a privacy policy that says it will not do so). If you have any concerns regarding the use of Third-Party App's and your information you may contact the Federal Trade Commission (FTC) and file a complaint at <https://reportfraud.ftc.gov/#/>.

Effective Date: 10/01/2023

Original Notice: 04/01/2003

Revised: 04/01/2011

04/01/2013

08/01/2021

10/01/2023

07/2025

CHAPTER 6: Your rights and responsibilities

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of Generations Valor (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

CHAPTER 6: Your rights and responsibilities

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with:

Oklahoma Board of Medical Licensure and Supervision
101 NE 51st St
Oklahoma City, OK 73105-1821

CHAPTER 6: Your rights and responsibilities

Phone: 1-800-381-4519 (toll-free) or (405) 962-1400 (local)

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint— **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and it's not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711)**
- **Call your local SHIP** at 1-800-763-2828
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711)**
- **Call your local SHIP** at 1-800-763-2828
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: <https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf>)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)

Section 1.9 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

CHAPTER 6: Your rights and responsibilities

Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Customer Care with any suggestions.

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Care at 1-844-280-5555 (toll-free)(TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan member ID card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
 - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

*If you have a problem or complaint
(coverage decisions, appeals,
complaints)*

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Contact State Health Insurance Counseling Program (SHIP) at 1-800-763-2828. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

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

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- Visit www.medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision,

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.globalhealth.com.)

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at www.globalhealth.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions, we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 Appeal**Legal Terms:**

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal.

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we *shouldn't* take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we receive the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision or turning down your appeal**.) In this case, the independent review organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about quality of your hospital care.
- Your right **to request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at <https://www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im>.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.***How can you contact this organization?***

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can see a sample notice online at www.CMS.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said no to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending**Legal Term:**

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to request a fast track appeal to ask us to keep covering your care for a longer period of time.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with the plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: The Quality Improvement Organization conducts an independent review of your case.**Legal Term:**

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you its decision.***What happens if the reviewers say yes?***

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.***What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, (for a total of 5 levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint**Legal Terms:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Care will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Here's how it works:
 - You may file a complaint by calling our Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711); sending it by fax at: 1-405-280-5294; or by mail at: GlobalHealth Grievances and Appeals Unit, PO Box 2658, Oklahoma City, OK 73101.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

- You must file your complaint no later than 60 calendar days of the event that became the reason for the complaint, and we will provide you with a response as expeditiously as your health status requires but no later than 30 calendar days from the day of receipt unless extended. If the plan grants itself a 14-day extension of the time frame, it will notify you in writing.
- You have the right to file an expedited (fast) complaint if we extend the timeframe to make a coverage decision. You may also file an expedited complaint if we refuse to grant you a request for an expedited coverage decision or appeal. When you request an expedited complaint, we will provide you with a response within 24 hours. If you would like to file an expedited complaint you may call us.
- Either you or your authorized representative may file a complaint. The person you name will act as your "representative." It may be a relative, a friend, a lawyer, a doctor, or any other person or provider you choose to act on your behalf. There may be someone who is already legally authorized to act as your authorized representative under State law. If you wish for someone in particular to act on your behalf, but that person has not yet been authorized by the Court or State law, call our Customer Care and ask for the form to give that person permission to legally act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Generations Valor (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

CHAPTER 8: Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Generations Valor (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without drug coverage.
 - Original Medicare *with* a separate Medicare drug plan.
 - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period**, you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.

CHAPTER 8: Ending membership in our plan

- Disenroll from our plan and get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Generations Valor (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If you have SoonerCare (Medicaid)
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drugs coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership, you can:

- **Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711)**
- Find the information in the **Medicare & You 2026** handbook

CHAPTER 8: Ending membership in our plan

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Generations Valor (HMO) when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Generations Valor (HMO) when your new plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	• Send us a written request to disenroll. Call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Generations Valor (HMO) when your coverage in Original Medicare starts.

Note: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services care through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

CHAPTER 8: Ending membership in our plan

SECTION 5 Generations Valor (HMO) must end our plan membership in certain situations

Generations Valor (HMO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
 - If you move or take a long trip, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711) to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General
- If you have questions or want more information on when we can end your membership, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Generations Valor (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Care at 1-844-280-5555 (toll-free) (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability.

GlobalHealth, Inc.:

- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including:
 - Qualified interpreters for individuals with disabilities
 - Information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities;

CHAPTER 9: Legal notices

- Provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact GlobalHealth's Customer Care at 1-844-280-5555 (toll-free). Our hours of operations are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. From April 1 to September 30 are Monday through Friday 8:00 a.m. to 8:00 p.m. TTY users should call 711).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, our Section 1557 Coordinator is available to help you. You can file a grievance in person, or by mail, fax or email:

Mailing address:	GlobalHealth Section 1557 Coordinator P.O. Box 2658 Oklahoma City, OK 73101-2658
Telephone number:	1-844-280-5555 (toll-free) 8:00 a.m. to 8:00 p.m., seven days a week, from October 1 through March 31. 8:00 a.m. to 8:00 p.m., Monday to Friday, from April 1 through September 30.
TTY number:	711
Fax number:	405-280-5294
Email:	section1557coordinator@globalhealth.com

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 20201
[1-800-368-1019](tel:1-800-368-1019), [800-537-7697](tel:800-537-7697) (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/complaints/index.html>.

This notice is available at our website: www.globalhealth.com.

CHAPTER 9: Legal notices

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Generations Valor (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Protections When Reporting Suspicions on Fraud, Waste, and/or Abuse

Under the rules of our plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation. You have the right to not be neglected, intimidated, physically or verbally abused, mistreated, or exploited. You also have the right to be treated with consideration, respect, and full recognition of your dignity, privacy, and individuality.

We can't deny services to you or punish you for exercising your rights. Your exercising of your rights won't negatively affect the way Generations Valor (HMO) and its providers, or CMS provide or arrange for the provision of services to you.

Protections When Reporting Suspicions on Fraud, Abuse and/or Waste (“Whistleblower Protections”)

GlobalHealth, Inc. complies with federal and state regulations establishing that any person and/or entity must report any suspicion of fraud, abuse and/or waste identified against Medicare and/or Medicaid Program. In complying with federal and state regulations, GlobalHealth, Inc. protects any person from any kind of retaliation who reports in good faith a suspicion of fraud, abuse and/or waste.

It's important that you report to GlobalHealth, Inc. any situation in which your healthcare services are being affected or can be affected because of identifying and/or reporting any suspicion of fraud, abuse and/or waste to GlobalHealth, Inc. and/or any federal and/or local agency. Suspicion of fraud, waste and/or abuse can be any service billed by a provider to GlobalHealth, Inc. and/or you that was not received, among any other scheme that you consider suspicious.

Report to GlobalHealth, Inc.

Remember, you may report any real or potential situation about non-compliance, financial exploitation, fraud, abuse and/or waste through our ACTright confidential report lines: **ACTright Hotline** (available 24 hours/7 days) at 1-877-627-0004 or Web Reporting Line at globalhealth.ethicspoint.com

CHAPTER 10:

Definitions

CHAPTER 10: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Generations Valor (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or 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 (for example \$10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are gotten. Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

CHAPTER 10: Definitions

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don’t need skilled medical care or skilled nursing care. Custodial care, provided by people who don’t have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you’re a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn’t involve coverage or payment disputes.

Home Health Aide – A person who provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must

CHAPTER 10: Definitions

provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Generations Valor (HMO) doesn't offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

CHAPTER 10: Definitions

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through the plan.

Part C – Go to Medicare Advantage (MA) Plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

CHAPTER 10: Definitions

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services based on specific criteria. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.



Notice of availability of language assistance services and auxiliary aids and services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-280-5555 (TTY 711).

Español: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-844-280-5555 (TTY 711).

Chinese: 如果您會說中文，我們可以為您提供免費語言幫助服務。也免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-280-5555 (TTY 711)。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-844-280-5555 (TTY 711).

French: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-280-5555 (TTY 711).

Vietnamese: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-844-280-5555 (TTY 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Auch entsprechende Hilfsmittel und Services zur Bereitstellung von Informationen in barrierefreien Formaten stehen kostenlos zur Verfügung. Rufen Sie 1-844-280-5555 (TTY 711) an.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 지원 및 서비스도 무료로 제공됩니다. 1-844-280-5555 (TTY 711) 로 전화하세요.

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по номеру 1-844-280-5555 (TTY 711).

Arabic: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. تتوفر المساعدات والخدمات المساعدات المناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالرقم 1-844-280-5555 (TTY 711).

Italian: Se parli italiano, sono a tua disposizione servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-844-280-5555 (TTY 711).

Portuguese: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-844-280-5555 (TTY 711).

French Creole: Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksèsib yo disponib tou gratis. Rele 1-844-280-5555 (TTY 711).

Polish: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-844-280-5555 (TTY 711).

Hindi: यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं आपके लिए उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी निः शुल्क उपलब्ध हैं। कॉल 1-844-280-5555 (TTY 711).

Japanese: 日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助援助やサービスも無料で利用できます。 1-844-280-5555 (TTY 711) に電話します。

Generations Valor (HMO) Customer Care

Method	Customer Care – Contact Information
Call	1-844-280-5555 (toll-free) Calls to this number are free. We are available 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30) Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
Fax	(405) 280-2960
Write	GlobalHealth, Inc. P.O. Box 1747 Oklahoma City, OK 73101
Website	www.globalhealth.com

State Health Insurance Counseling Program (Oklahoma SHIP)

State Health Insurance Counseling Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	1-800-763-2828
Write	State Health Insurance Counseling Program 400 NE 50th Street Oklahoma City, OK 73105
Website	https://www.oid.ok.gov/consumers/information-for-seniors/

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.