GlobalHealth

Generations Medicare Advantage Plans

2021 Summary of Benefits

January 1 – December 31, 2021

Generations Medicare Advantage Plan Options:

Generations Value (HMO)

Generations Classic (HMO)

Generations Classic Choice (HMO-POS)

Generations Select (HMO)

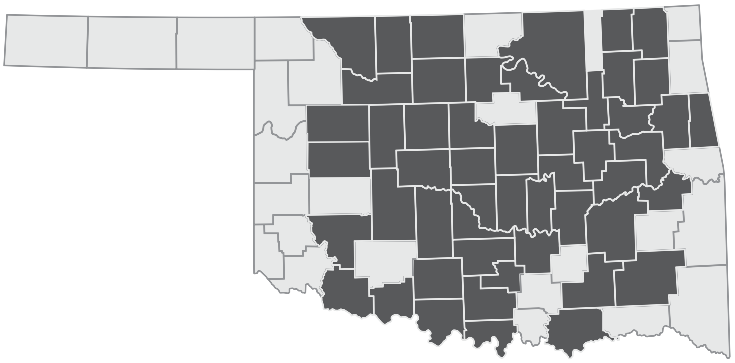
1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.
7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)
www.GlobalHealth.com/medicare

H3706_SB_2021_M

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

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please see the "Evidence of Coverage." The Evidence of Coverage can be found online at www.GlobalHealth.com, or you can request a copy from Customer Care at 1-844-280-5555 (TTY: 711).

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



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

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

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

2021

Medicare Advantage Plan

Without Prescription Drug Coverage

(No Medicare Part D)

Generations Value (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

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

2021

Medicare Advantage Prescription Drug (MA-PD) Plans

Generations Classic (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

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

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

PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.
*Costs for 90-day supply are higher at a Standard Pharmacy
For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

Generations Classic Choice (HMO-POS) Summary of Benefits

January 1, 2021 – December 31, 2021

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

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

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

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

1 = Prior Authorization Required
2 = Referral Required

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

PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.
*Costs for 90-day supply are higher at a Standard Pharmacy
For a full listing of benefits and limitations, please reference the plan's Evidence of Coverage at:
https://www.globalhealth.com/medicare-advantage/member-materials

Generations Select (HMO) Summary of Benefits

January 1, 2021 – December 31, 2021

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

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

1 = Prior Authorization Required
2 = Referral Required

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

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

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

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

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

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

Customer Care: 1-844-280-5555 (TTY: 711)

8 a.m. to 8 p.m., 7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)

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

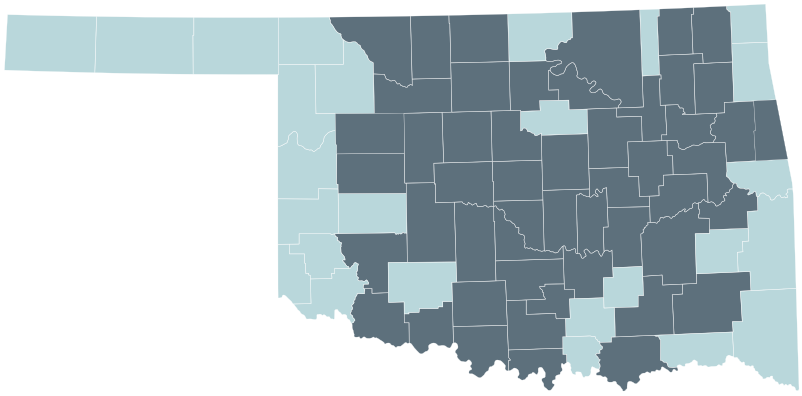
Provider Directory: www.GlobalHealth.com/search
Pharmacy Directory: www.GlobalHealth.com/pharmacy-directory

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

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

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

2021 Service Area



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

GlobalHealth
Generations Medicare Advantage Plans

For questions or to enroll:
1-844-322-8322 (TTY: 711)

www.GlobalHealthMedicare.com

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

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal. By calling the listed number you may be speaking with a licensed sales representative. You must continue to pay your Medicare Part B premium. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711). CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).