GlobalHealth

Generations Classic Plus (HMO)

ANNUAL NOTICE OF CHANGES

January 1–December 31, 2023

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

GlobalHealth is an HMO/SNP HMO plan with a Medicare contract and a state Medicaid contract for D-SNP. Enrollment in GlobalHealth depends on contract renewal.

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Generations Classic Plus (HMO) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2023

You are currently enrolled as a member of Generations Classic Choice (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.GlobalHealth.com. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost-sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2022, you will stay in Generations Classic Plus (HMO).
- To change to a **different plan,** you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Generations Classic Plus (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Care number at 1-844-280-5555 (toll-free) for additional information. (TTY users should 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 information is also available in Spanish and large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Generations Classic Plus (HMO)

- GlobalHealth is an HMO/SNP HMO plan with a Medicare contract and a state Medicaid contract for D-SNP. Enrollment in GlobalHealth depends on contract renewal.
- When this document says "we," "us," or "our", it means GlobalHealth, Inc. When it says "plan" or "our plan," it means Generations Classic Plus (HMO).

Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Generations Classic Plus (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$10	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$3,900 for in-network covered services, $10,000 for combined in-network and out-of-network covered services.	$3,900
Doctor office visits	Primary care visits: In-network - $0 per visit Out-of-network - not covered Specialist visits: In-network - $45 per visit Out-of-network - 30% of the total cost per visit	Primary care visits: $0 per visit Specialist visits: In-network - $30 per visit Out-of-network - not covered
Inpatient hospital stays	In-network: You pay a $395 copay per day for days 1 through 5. There is no coinsurance, copayment, or deductible for days 6 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190. Out-of-network: You pay 30% of the total cost	In-network: You pay a $245 copay 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. Out-of-network: Not covered
Part D prescription drug coverage	Deductible: $0	Deductible: $0

Cost	2022 (this year)	2023 (next year)
(See Section 2.5 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5	Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $47 • Drug Tier 3 Insulin: $35 • Drug Tier 4: 50% of the total cost • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35 Preferred 30-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 3 Insulin: $35 • Drug Tier 4: 40% of the total cost • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35

Cost	2022 (this year)	2023 (next year)
	• Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost Standard 100-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost Preferred 100-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $84 • Drug Tier 4: 40% of the total cost Standard 100-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost Preferred 100-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $84	Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $47 • Drug Tier 3 Insulin: $35 • Drug Tier 4: 50% of the total cost • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost. • Drug Tier 5 Insulin: $35 Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $42 • Drug Tier 3 Insulin: $35 • Drug Tier 4: 40% of the total cost • Drug Tier 4 Insulin: $35 • Drug Tier 5: 33% of the total cost • Drug Tier 5 Insulin: $35 Standard 100-day Retail Cost-Share: • Drug Tier 1: $15

Cost	2022 (this year)	2023 (next year)
	• Drug Tier 4: 40% of the total cost	• Drug Tier 2: $45 • Drug Tier 3: $141 • Drug Tier 3 Insulin: $105 • Drug Tier 4: 50% of the total cost • Drug Tier 4 Insulin: $105 Preferred 100-day Retail Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $84 • Drug Tier 3 Insulin: $84 • Drug Tier 4: 40% of the total cost • Drug Tier 4 Insulin: $105 Standard 100-day Mail-order Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $141 • Drug Tier 3 Insulin: $105 • Drug Tier 4: 50% of the total cost • Drug Tier 4 Insulin: $105 Preferred 100-day Mail-order Cost-Share: • Drug Tier 1: $0

Cost	2022 (this year)	2023 (next year)
		• Drug Tier 2: $0 • Drug Tier 3: $84 • Drug Tier 3 Insulin: $84 • Drug Tier 4: 40% of the total cost • Drug Tier 4 Insulin: $105

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Generations Classic Plus (HMO) in 2023

On January 1, 2023, GlobalHealth, Inc. will be combining Generations Classic Choice (HMO-POS) with one of our plans, Generations Classic Plus (HMO). The information in this document tells you about the differences between your current benefits in Generations Classic Choice (HMO-POS) and the benefits you will have on January 1, 2023 as a member of Generations Classic Plus (HMO).

If you do nothing by December 7, 2022, we will automatically enroll you in our Generations Classic Plus (HMO). This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through Generations Classic Plus (HMO). If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$10	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.

- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,900 for in-network covered services, $10,000 for combined in-network and out-of-network covered services.	$3,900 for in-network covered services, out-of-network services not covered. Once you have paid $3,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.GlobalHealth.com. You may also call Customer Care for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the *2023 Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the *2023 Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 2.4 – Changes to Benefits and Costs for Medical Services

We are making changes to our costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Acupuncture for chronic low back pain	You pay a $25 copay for Medicare-covered acupuncture for chronic low back pain services.	You pay a $30 copay for Medicare-covered acupuncture for chronic low back pain services.
Advance care planning	Advance care planning automated services are <u>not</u> covered.	There is no coinsurance, copay, or deductible for advance care planning to create your living will and/or health care power of attorney documents through Vital Decisions.
Cardiac rehabilitation services	You pay a $10 copay per office visit for Medicare-covered cardiac rehabilitation services or intensive cardiac rehabilitation services.	You pay a $30 copay per office visit for Medicare-covered cardiac rehabilitation services or intensive cardiac rehabilitation services.
Dental services	<u>In-network:</u> • You pay a $45 copay per office visit for Medicare-covered dental services. <u>Out-of-network:</u> You pay 30% of the total cost.	<u>In-network:</u> You pay a $30 copay per office visit for Medicare-covered dental services. <u>Out-of-network:</u> Not covered.
Dental services - comprehensive	Non-routine services: • There is no coinsurance, copay, or deductible for nitrous oxide and other sedation. • You pay 30% of the total cost for other non-routine services. Diagnostic services: • There is no coinsurance, copay, or deductible for diagnostic services. Restorative services:	Non-routine services: • There is no coinsurance, copay, or deductible for nitrous oxide and other sedation. • You pay 20% of the total cost for other non-routine services. Diagnostic services: • There is no coinsurance, copay, or deductible for diagnostic services.

Cost	2022 (this year)	2023 (next year)
	• There is no coinsurance, copay, or deductible for fillings. • You pay 30% of the total cost for other restorative services. Endodontics: • You pay 30% of the total cost for endodontics. Periodontics: • There is no coinsurance, copay, or deductible for periodontic cleanings. See Dental services - preventive. • You pay 30% of the total cost for periodontics. Extractions: • You pay 30% of the total cost for extraction services. Prosthodontics • You pay 30% of the total cost for prosthodontics. We will only pay up to a total of $1,000 for preventive and comprehensive dental services per year.	Restorative services: • There is no coinsurance, copay, or deductible for fillings. Limited to one per 24 months per tooth, per surface • You pay 20% of the total cost for other restorative services. Endodontics: • You pay 20% of the total cost for endodontics. Periodontics: • There is no coinsurance, copay, or deductible for periodontic cleanings. See Dental services - preventive. • You pay 20% of the total cost for periodontics. Limited to scaling in the presence of generalized moderate or severe gingival inflammation, full mouth 2 every 12 months and full mouth debridement limited to one per 36 months. Extractions: • You pay 20% of the total cost for extraction services. Prosthodontics • You pay 20% of the total cost for prosthodontics.

Cost	2022 (this year)	2023 (next year)
		We will only pay up to a total of $2,000 for preventive and comprehensive dental services per year.
Dental services - preventive	• Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 2 every year) • Oral exam (for up to 2 every year) We will only pay up to a total of $1,000 for preventive and comprehensive dental services per year.	Cleaning: • Standard cleaning limited to two every 12 months • Periodontal maintenance (cleaning) limited to four every 12 months.) Dental x-ray(s): • (Bitewing (1-4) limited to one every 12 months • Panoramic radiographic image, intraoral complete series, 7-8 vertical bitewings, limited to one every 36 months • Intraoral occlusal limited to two every 24 months) Oral exam: • Limited exams limited to three every 12 months • Routine exams limited to two every 12 months • Comprehensive exams limited to one every 36 months) We will only pay up to a total of $2,000 for preventive and comprehensive dental services per year.

Cost	2022 (this year)	2023 (next year)
Dermatology services	In-network: You pay a $45 copay per office visit for Medicare-covered dermatology services. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per office visit for Medicare-covered dermatology services. Out-of-network: Not covered.
Dialysis services	Out-of-network: You pay 20% of the total cost for Medicare-covered dialysis, either inside or outside our service area.	Out-of-network: Dialysis services not covered while in our service area.
Hearing services	In-network: You pay a $45 copay per office visit for Medicare-covered specialist services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per visit for specialist exams to diagnose and treat hearing and balance issues. Out-of-network: Not covered.
Hearing services - hearing aids	We will only pay up to a total of $500 for hearing aid devices per year.	We will only pay up to a total of $1,000 for hearing aid devices per year.
Inpatient hospital care	In-network: For each Medicare-covered hospital stay at an in-network hospital: • You pay a $395 copay per day for days 1 through 5. • There is no coinsurance, copay, or deductible for days 6 through 90. • There is no coinsurance, copay, or deductible for days 91 through 190. Out-of-network:	In-network: For each Medicare-covered hospital stay at an in-network hospital: • You pay a $245 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90. • There is no coinsurance, copay, or deductible for days 91 through 190.

Cost	2022 (this year)	2023 (next year)
	For each Medicare-covered hospital stay at an out-of-network hospital: • You pay 30% of the total cost.	Out-of-network: Not covered.
Inpatient mental health care	In-network: For each Medicare-covered hospital stay at an in-network hospital: • You pay a $275 copay per day for days 1 through 6. • There is no coinsurance, copay, or deductible for days 7 through 90. Out-of-network: For each Medicare-covered hospital stay at an out-of-network hospital: • You pay30% of the total cost.	In-network: For each Medicare-covered hospital stay in a network hospital: • You pay a $245 copay per day for days 1 through 7. • There is no coinsurance, copay, or deductible for days 8 through 90. Out-of-network: Not covered.
Other healthcare professional	In-network: You pay a $45 copay per office visit to see a physician assistant, nurse practitioner, or other provider in a specialist's office. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per office visit to see a physician assistant, nurse practitioner, or other provider in a specialist's office. Out-of-network: Not covered.
Outpatient blood services	Out-of-network: There is no coinsurance, copay, or deductible for Medicare-covered blood services.	Out-of-network: Not covered.
Outpatient diagnostic tests and therapeutic services and supplies - other outpatient	You pay a $250 copay per visit for Medicare-covered services in a non-preferred (hospital based) radiological facility.	You pay a $275 copay per visit for Medicare-covered services in a non-preferred (hospital based) radiological facility.

Cost	2022 (this year)	2023 (next year)
diagnostic tests (e.g., CT, MRI, etc.)		
Outpatient hospital observation	In-network: You pay a $300 copay per visit for Medicare-covered observation services. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $275 copay per visit for Medicare-covered observation services. Out-of-network: Not covered.
Outpatient hospital services - hyperbaric oxygen therapy	You pay a $40 copay per visit for Medicare-covered care.	You pay a $30 copay per visit for Medicare-covered care.
Outpatient hospital services - observation services	In-network: You pay a $300 copay per visit for Medicare-covered observation services. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $275 copay per visit for Medicare-covered observation services. Out-of-network: Not covered.
Outpatient mental health care	There is no coinsurance, copay, or deductible for Medicare-covered individual or group sessions.	You pay a $30 copay per visit for Medicare-covered individual or group sessions.
Outpatient rehabilitation services	You pay a $20 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy.	You pay a $30 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy.
Outpatient substance abuse services	There is no coinsurance, copay, or deductible Medicare-covered individual or group sessions.	You pay a $30 copay per visit for Medicare-covered individual or group sessions.
Outpatient surgery	You pay a $250 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $320 copay per visit for Medicare-covered services in an outpatient surgery department.	You pay a $225 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $275 copay per visit for Medicare-covered services in an outpatient surgery department.

Cost	2022 (this year)	2023 (next year)
Over-the-counter (OTC) drugs and supplies	You are eligible for a $50 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order services, including nicotine replacement therapy.	You are eligible for a $100 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order services and some retail stores, including nicotine replacement therapy, through the Smart Wallet.
Personal emergency response system	Personal emergency response system is not covered.	There is no coinsurance, copay, or deductible for personal emergency response system device and monitoring.
Physician/Practitioner services, including doctor's office visits - specialist	In-network: You pay a $45 copay per office visit for Medicare-covered specialist services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per office visit for Medicare-covered specialist services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. Out-of-network: Not covered.
Podiatry services	In-network: You pay a $45 copay per office visit for Medicare-covered specialist services, except specialized outpatient diagnostic tests and Part B drugs, during an office visit. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per office visit for Medicare-covered podiatry services. Out-of-network: Not covered.
Psychiatric services	There is no coinsurance, copay, or deductible for Medicare-covered individual or group sessions.	You pay a $30 copay per visit for Medicare-covered individual or group sessions.
Pulmonary rehabilitation services	You pay a $10 copay per outpatient visit for	You pay a $20 copay per outpatient visit for

Cost	2022 (this year)	2023 (next year)
	Medicare-covered pulmonary rehabilitation services.	Medicare-covered pulmonary rehabilitation services.
Skilled nursing facility	Out-of-network: For each Medicare-covered skilled nursing facility stay per benefit period: • You pay 30% of the the total cost.	Out-of-network: Not covered.
Smart Wallet	Smart Wallet is not covered.	The Smart Wallet is a prepaid debit card with a combined annual limit of $500 per year to reduce your out of pocket expenses for dental, vision, and hearing services. In addition, the Smart Wallet has a separate allowance of $100 per quarter for over-the-counter items.
Supervised exercise therapy	You pay a $10 copay per outpatient visit for Medicare-covered SET services. Prior authorization may be required.	You pay a $25 copay per outpatient visit for Medicare-covered SET services. Prior authorization may be required.
Vision care	In-network: There is no coinsurance, copay, or deductible for Medicare-covered exams to diagnose and treat diseass and conditions of the eye. Out-of-network: You pay 30% of the total cost.	In-network: You pay a $30 copay per visit for Medicare-covered exams to diagnose and treat diseass and conditions of the eye. Out-of-network: Not covered.
Vision care - supplemental eyewear	We will only pay up to a total of $200 for supplemental eyewear per year combined in-network and out-of-network.	We will only pay up to a total of $200 for supplemental eyewear per year in-network.

Section 2.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up-to-date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Customer Care and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2022 to 2023.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 - Preferred Generic:** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 - Generic:** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 - Preferred Brand:** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 - Non-Preferred Drug:** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 - Specialty:** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:*	Your cost for a one-month supply at a network pharmacy: **Tier 1 - Preferred Generic:** *Standard cost-sharing:* You pay $5 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. **Tier 2 - Generic:** *Standard cost-sharing:* You pay $15 per prescription. *Preferred cost-sharing:* You pay $10 per prescription. **Tier 3 - Preferred Brand:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay $47 per prescription for all other drugs. *Preferred cost-sharing:* You pay $35 per insulin prescription. You pay $42 per prescription for all other drugs. **Tier 4 - Non-Preferred Drug:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay 50% of the total cost for all other drugs.

Stage	2022 (this year)	2023 (next year)
	You pay 33% of the total cost. _____ Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	*Preferred cost-sharing:* You pay $35 per insulin prescription. You pay 40% of the total cost for all other drugs. **Tier 5 - Specialty:** *Standard cost-sharing:* You pay $35 per insulin prescription. You pay 33% of the total cost for all other drugs. *Preferred cost-sharing:* You pay $35 per insulin prescription. You pay 33% of the total cost for all other drugs. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

SECTION 3 Administrative Changes

Description	2022 (this year)	2023 (next year)
Dental administration	Your preventive and comprehensive dental services are administered by Careington BenefitSolutions. See your *Evidence of Coverage* or go to www.GlobalHealth.com for more information.	Your preventive and comprehensive dental services are administered by DentaQuest. See your *Evidence of Coverage* or go to www.GlobalHealth.com for more information.

Description	2022 (this year)	2023 (next year)
Excluded drugs	Excluded drugs are not covered.	Excluded drugs are included in Tier 1 and Tier 2.
Over-the-counter administration	Spend your allowance on over-the-counter items and products through a mail-order catalog. See your *Evidence of Coverage* or go to www.GlobalHealth.com for more information.	Spend your debit card allowance on over-the-counter items and products through a mail-order catalog or in many stores. You will receive a new debit card, called Smart Wallet. See your *Evidence of Coverage* or go to www.GlobalHealth.com for more information.
Plan number	Your plan number is H3706-021.	Your plan number is H3706-023.
Point-of-service option	You may go out-of-network for certain services at a different cost share. • Ambulance - air • Ambulance - ground • Dialysis services • Eye exams - Medicare-covered • Eyewear - Medicare-covered and supplemental • Hearing exams - Medicare-covered • Inpatient hospital • Inpatient psychiatric hospital	Point-of-service option is not available.

Description	2022 (this year)	2023 (next year)
	• Observation services • Opioid treatment program • Other health care professional • Outpatient blood services • Outpatient hospital services • Podiatry services • Specialist services • Skilled nursing facility Out-of-network/ non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our Customer Care number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.	
Service area change	Cleveland, Creek, Lincoln, Oklahoma, Pottawatomie, Rogers, and Tulsa	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

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Generations Classic Plus (HMO)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Generations Classic Plus (HMO).

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2). As a reminder, GlobalHealth, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Generations Classic Plus (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Classic Plus (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 5 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 6 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Oklahoma, the SHIP is called Senior Health Insurance Counseling Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Senior Health Insurance Counseling Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Counseling Program at 1-800-763-2828. You can learn more about Senior Health Insurance Counseling Program by visiting their website (https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/).

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

- The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
- Your State Medicaid Office (applications).

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Oklahoma HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Oklahoma HIV Drug Assistance Program (HDAP) at 1-405-271-4636.

SECTION 8 Questions?

Section 8.1 – Getting Help from Generations Classic Plus (HMO)

Questions? We're here to help. Please call Customer Care at 1-844-280-5555 (toll-free). (TTY only, call 711). We are available for phone calls 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). Calls to these numbers are free.

Read your *2023 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for Generations Classic Plus (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.GlobalHealth.com. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.GlobalHealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Customer Care: 1-844-280-5555 (toll-free)
TTY users call 711
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