

# 2023

## Benefits Overview Oklahoma



### **Generations Medicare Advantage Plan Options:**

- H3706-001 Generations Classic Rewards (HMO)
- H3706-023 Generations Classic Plus (HMO)
- H3706-024 Generations Chronic Care (HMO C-SNP)
- H3706-025 Generations Chronic Care Savings (HMO C-SNP)
- H3706-028 Generations Dual Support (HMO D-SNP)
- H3706-029 Generations Dual Premier (HMO D-SNP)
- H3706-009 Generations Valor (HMO-POS)

Call now to speak to a licensed agent!

**1-855-766-7881 (TTY: 711)**

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# Why Choose GlobalHealth?

## Medicare Advantage Plans (MA)

### About GlobalHealth

- Local, Oklahoma-Based Health Maintenance Organization (HMO)
- Available in 26 Counties for 2023
- 7 Medicare Advantage Plans
- Local Customer Care, Case Management and Pharmacy Teams
- Thousands of Quality Providers, Pharmacies and Many Major Hospitals

### What makes GlobalHealth Unique?



#### We are High-touch.

Our local customer care, case management and pharmacy teams provide you with personal assistance to help you move through the increasingly complex world of Medicare. We are approachable, easy to reach and go above and beyond to help you.



#### We are Affordable.

We offer a number of money-saving benefits designed to keep more money in your pocket and extend your dollars on your medical expenses.



#### We are your Health Partner.

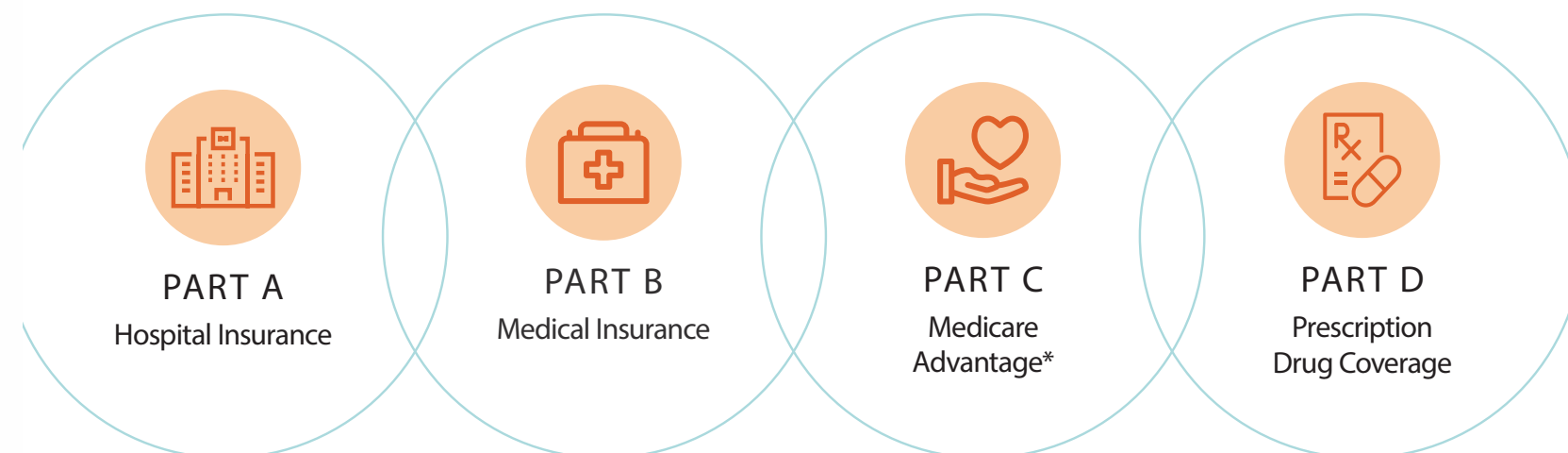
Not only will we help enroll you in the right plan, but you'll also have ongoing access to tireless health advocates who support your best health, even between doctor visits.

### Are you eligible for Generations Medicare Advantage Plans?

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

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

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



\*Includes Part A, Part B, and sometimes Part D Coverage

# Medicare Part D

## Prescription Drug Coverage (Three Stages)

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### Stage One

**Initial Coverage Stage**  
The plan pays its share of the cost, and you pay your share (copayment/coinsurance) until your total drug costs reach \$4,660.

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

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### Stage Two

**Coverage Gap Stage**  
You will pay no more than 25% for covered generics or 25% on all other drugs plus a portion of the dispensing fee until you reach \$7,400.

Generic Example: Drug = \$50 Plan pays = 75% (\$37.50) You pay = 25% (\$12.50)	Gap Coverage for the following: • All Tier 1 drugs • Tier 3: Insulin and antidiabetics*
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3

### Stage Three

**Catastrophic Coverage Stage**  
You will pay the greater of 5% of the cost or \$4.15 for generics and \$10.35 for all other drugs.

Generic Example:  
Drug = \$50  
Plan pays = \$45.85  
You pay = \$4.15

GlobalHealth Medicare Advantage plans do not have a deductible stage. D-SNP members pay \$0 during all payment stages.

## 5-Tier Formulary

You'll notice in the prescription drug formulary that drugs are divided into a tier system. Simply put, the more expensive the drug, the higher the tier. Each tier will have a defined out-of-pocket cost that you must pay before receiving the prescription medication. Please note, D-SNP plans only have a single tier for covered prescription drugs. The Tier system is as follows:

Tier 1 (Preferred Generic)

Commonly prescribed Preferred Generic Drugs

Tier 2 (Generic)

Generic Drugs that may have a low copay

Tier 3 (Preferred Brand)

Preferred Brand Drugs that do not have a generic equal and are the lowest-cost brand name drugs

Tier 4 (Non-Preferred Drugs)

Non-Preferred Drugs include Non-Preferred Brand Drugs and Non-Preferred Generic Drugs

Tier 5 (Specialty Tier)

Specialty Drugs are the most expensive in the Tier system and are used to treat complex conditions, such as cancer





## Need Extra Help?

### You May Qualify!

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

To find out if you qualify, call:

- GlobalHealth: 1-855-766-7881 (TTY: 711)\*
- Medicare: 1-800-MEDICARE (1-800-633-4227),  
24 hours a day, 7 days a week (TTY: 1-877-486-2048)
- Social Security Office: 1-800-772-1213, 7:00 AM to 7:00 PM  
(TTY: 1-800-325-0778)
- State Medicaid (SoonerCare Helpline): 1-800-987-7767

## What do you need to know about Medicare?



### Medicare Advantage Enrollment Dates

#### Pre-enrollment Oct. 1 - Oct. 14.

Medicare plan information is released. This is an opportunity for you to review and compare different Medicare plans that meet your needs and budget.

#### Annual Enrollment Oct. 15 - Dec. 7

This short window of time is when Medicare eligibles can join, switch or drop a Medicare Advantage plan.

#### Open Enrollment Jan. 1 - Mar. 31

Medicare Advantage plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare.

#### Special Enrollment Period Apr. 1 - Oct. 14

Medicare Advantage plan members cannot make changes to their current plan unless they qualify for a special enrollment period.

# What is a Special Enrollment Plan? (SEP)

You can enroll in a Medicare Advantage plan during a 7-month window around your 65th birthday:



## Special Enrollment Period

Certain qualifying events may allow a Medicare eligible person to make plan changes throughout the year.

If you answer yes, you may qualify for Special Enrollment Period:

- Do you have both Medicare and Medicaid?
- Do you qualify for Extra Help paying for your prescriptions?
- Have you recently moved and your current plan is not offered in your service area?
- Are you leaving your employer or union coverage?
- Do you qualify for a special needs plan for diabetes, chronic heart failure or cardiovascular disease?

# What are Chronic Special Needs Plans? C-SNP

## What is a C-SNP plan?

C-SNPs are types of Medicare Advantage plans designed for Medicare beneficiaries with chronic conditions. Plans may offer C-SNP plans for only one condition or a group of conditions.

## What conditions qualify?

The Centers for Medicare and Medicaid defines which condition or conditions a Medicare Advantage plan may cover through a C-SNP plan. GlobalHealth’s C-SNP plans are for enrollees with:

- Chronic heart failure
- Diabetes
- Cardiovascular disease including cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and chronic venous thromboembolic disorder

## Who is eligible?

GlobalHealth C-SNP plans are offered to all service area counties in 2023. To be eligible to enroll, you must live in our service area, have Medicare Part A and Part B and have one or more of the above qualifying conditions.

## How do C-SNPs help?

Members enrolled in a C-SNP plan receive additional proactive case management services to help manage chronic conditions. Members receive a tailored health care action plan tied directly to help them reach their optimal health.

## GlobalHealth C-SNP Features and Benefits



- Standard Diabetic Testing Supplies **Covered at No Cost**
- **Free** pair of Therapeutic Custom-Molded Shoes and Inserts\*
- **\$35 Copay** for Insulins through the Part D Senior Savings Model
- **Additional Coverage** for Tier 3 Oral Antidiabetics through the Gap Coverage Stage

\*Prior authorization may be required. For a complete listing of benefits and limitations, please reference the plan’s Evidence of Coverage.



# What are Dual Special Needs Plans?

D-SNP

GlobalHealth also offers Dual Special Needs Plans that provide additional financial help for medical expenses for persons who qualify. To be eligible, you must live in our service area, have Medicare Part A and Part B and qualify for Medicaid.

## GlobalHealth D-SNP Features and Benefits

Some of the enhanced benefits you get with a GlobalHealth Dual Special Needs plan are:



- **Monthly allowance** that can be used for utility assistance
- **14 FREE meals** once per year
- **\$0 copay** on ALL formulary drugs
- and **More!**

Call to speak to one of our licensed agents to see if you qualify or to get help applying for Medicaid.

1-855-766-7881 (TTY: 711)



# What's Next?

## What to Expect When Enrolling

Welcome to the GlobalHealth family!  
After you enroll in your Generations Medicare Advantage Plan, use the step-by-step guide below to know what to expect next. Be sure to check your mail for these communications!

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

Questions? You can call our friendly Customer Care team for answers to your questions at:

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

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



## Generations Medicare Advantage Plans

County	H3706-001 Generations Classic Rewards (HMO)	H3706-023 Generations Classic Plus (HMO)	H3706-024 Generations Chronic Care (HMO C-SNP)	H3706-025 Generations Chronic Care Savings (HMO C-SNP)	H3706-028 Generations Dual Support (HMO D-SNP)	H3706-029 Generations Dual Premier (HMO D-SNP)	H3706-009 Generations Valor (HMO-POS)
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	✓	✓	✓	✓	✓	✓	✓
Wagoner	✓	✓	✓	✓	✓	✓	✓

Benefit limitations, prior authorizations, and/or referrals may apply. Please reference the plan's Evidence of Coverage for a complete description of benefits.





# Generations Medicare Advantage Plans Benefits Review

	H3706-001 Generations Classic Rewards (HMO)	H3706-023 Generations Classic Plus (HMO)	H3706-024 Generations Chronic Care (HMO C-SNP)	H3706-025 Generations Chronic Care Savings (HMO C-SNP)	H3706-028 Generations Dual Support (HMO D-SNP)	H3706-029 Generations Dual Premier (HMO D-SNP)	H3706-009 Generations Valor (HMO-POS)
Monthly Plan Premium	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Deductible	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Medicare Part B Premium Buydown	\$75	\$0	\$0	\$100	\$0	\$0	\$75
Maximum Out-of-Pocket (MOOP) Annually	\$3,900	\$3,900	\$3,450	\$3,900	\$3,650	\$3,650	\$3,900 in-network, \$4,900 combined
INPATIENT CARE							
Inpatient Hospital Coverage	\$295 per day (Days 1-7)	\$245 per day (Days 1-7)	\$195 per day (Days 1-7)	\$275 per day (Days 1-7)	\$0	\$0	\$295 per day (Days 1-7) in-network \$345 per day (Days 1-7) out-of-network
Inpatient Mental Health Care	\$295 per day (Days 1-7)	\$245 per day (Days 1-7)	\$195 per day (Days 1-7)	\$275 per day (Days 1-7)	\$0	\$0	\$295 per day (Days 1-7) in-network \$345 per day (Days 1-7) out-of-network
Skilled Nursing Facility (SNF)	\$0 (Days 1-20); \$184 per day (Days 21-100)	\$0 (Days 1-20); \$184 per day (Days 21-100)	\$0 (Days 1-20); \$184 per day (Days 21-100)	\$0 (Days 1-20); \$184 per day (Days 21-100)	\$0	\$0	\$0 (Days 1-20); \$184 per day (Days 21-100) in-network \$225 per day (Days 1-25); \$0 (Days 26-100)
OUTPATIENT CARE							
PCP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Specialist	\$40	\$30	\$20	\$35	\$0	\$0	\$35 in-network, \$55 out-of-network

Benefit limitations, prior authorizations, and/or referrals may apply. Please reference the plan’s Evidence of Coverage for a complete description of benefits.

	H3706-001 Generations Classic Rewards (HMO)	H3706-023 Generations Classic Plus (HMO)	H3706-024 Generations Chronic Care (HMO C-SNP)	H3706-025 Generations Chronic Care Savings (HMO C-SNP)	H3706-028 Generations Dual Support (HMO D-SNP)	H3706-029 Generations Dual Premier (HMO D-SNP)	H3706-009 Generations Valor (HMO-POS)
Chiropractic Services	\$20	\$20	\$20	\$20	\$0	\$0	\$20
Podiatry Services	\$40	\$30	\$20	\$35	\$0	\$0	\$35
Home Health Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Ambulatory Surgery Center (ASC)	\$250	\$225	\$175	\$225	\$0	\$0	\$250
Outpatient Hospital Surgery	\$320	\$275	\$225	\$275	\$0	\$0	\$320
Ambulance (One-way trip)	\$250	\$250	\$240	\$240	\$0	\$0	\$240
Emergency Care	\$90	\$90	\$90	\$90	\$0	\$0	\$90
Worldwide Urgent Care and Worldwide Emergency Care (Does not accumulate to MOOP)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)	\$50,000 (Copay \$90)
Urgently Needed Services	\$30	\$30	\$20	\$20	\$0	\$0	\$15
Outpatient Labs and X-rays	\$0	\$0	\$0	\$0	\$0	\$0	\$5 labs; \$0 x-rays
Diagnostic Radiology – Free Standing Facility (MRI, CT, PET, etc.)	\$180	\$180	\$175	\$180	\$0	\$0	\$180
Therapeutic Radiology	\$50	\$50	\$50	\$50	\$0	\$0	\$50
Physical, occupational, or speech therapy	\$20	\$30	\$20	\$35	\$0	\$0	\$20
PREVENTIVE CARE							
Preventive Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OUTPATIENT MEDICAL SUPPLIES							
Durable Medical Equipment <sup>2</sup> (e.g., Continuous glucose monitors (CGM), wheelchairs, oxygen)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	\$0	\$0	20% coinsurance

Benefit limitations, prior authorizations, and/or referrals may apply. Please reference the plan’s Evidence of Coverage for a complete description of benefits.



	H3706-001 Generations Classic Rewards (HMO)	H3706-023 Generations Classic Plus (HMO)	H3706-024 Generations Chronic Care (HMO C-SNP)	H3706-025 Generations Chronic Care Savings (HMO C-SNP)	H3706-028 Generations Dual Support (HMO D-SNP)	H3706-029 Generations Dual Premier (HMO D-SNP)	H3706-009 Generations Valor (HMO-POS)
Standard Diabetic Testing Supplies	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prosthetics and Related Supplies <sup>2</sup> (e.g., Braces, artificial limbs)	\$0 surgically implanted; 20% external devices and medical supplies	\$0 surgically implanted; 20% external devices and medical supplies	\$0 surgically implanted; 20% external devices and medical supplies	\$0 surgically implanted; 20% external devices and medical supplies	\$0	\$0	\$0 surgically implanted; 20% external devices and medical supplies
PART B DRUGS							
Medicare Part B Drugs (Includes Chemotherapy)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	\$0	\$0	20% coinsurance
PART D DRUGS							
Deductible	\$0	\$0	\$0	\$0	\$0	\$0	N/A
Initial Cover Limit (ICL)	\$4,660	\$4,660	\$4,660	\$4,660	\$4,660	\$4,660	N/A
Tier 1: Preferred Retail 100-day supply	\$0	\$0	\$0	\$0	\$0	\$0	N/A
Tier 2: Preferred Retail 100-day supply	\$0	\$0	\$0	\$0	\$0	\$0	N/A
Tier 3: Preferred Retail 100-day supply	\$84	\$84	\$84	\$84	\$0	\$0	N/A
Tier 4: Preferred Retail 100-day supply	40% coinsurance	40% coinsurance	\$270	\$270	\$0	\$0	N/A
Tier 1: Preferred Retail 30-day supply	\$0	\$0	\$0	\$0	\$0	\$0	N/A
Tier 2: Preferred Retail 30-day supply	\$10	\$10	\$5	\$5	\$0	\$0	N/A
Tier 3: Preferred Retail 30-day supply	\$42	\$42	\$42	\$42	\$0	\$0	N/A
Tier 4: Preferred Retail 30-day supply	40% coinsurance	40% coinsurance	\$90	\$90	\$0	\$0	N/A
Tier 5: Preferred Retail 30-day supply	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	\$0	\$0	N/A
GAP Coverage	Yes	Yes	Yes	Yes	Yes	Yes	N/A

Benefit limitations, prior authorizations, and/or referrals may apply. Please reference the plan’s Evidence of Coverage for a complete description of benefits.

Important Message About What You Pay for Vaccines and Insulin: Our plan covers most Part D vaccines at no cost to you. 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.

Call Customer Care for more information.

	H3706-001 Generations Classic Rewards (HMO)	H3706-023 Generations Classic Plus (HMO)	H3706-024 Generations Chronic Care (HMO C-SNP)
SUPPLEMENTAL BENEFITS			
Hearing Services	\$1,000	\$1,000	\$1,000
Dental Services	\$1,500	\$2,000	\$2,000
Vision Services	\$200	\$200	\$200
Smart Wallet	\$500/yr (Hearing, Dental and/or Vision); \$100/qtr (OTC)	\$500/yr (Hearing, Dental and/or Vision); \$100/qtr (OTC)	\$1,000/yr (Hearing, Dental and/or Vision); \$150/qtr (OTC and/or Groceries)
Transportation	12 one-way trips	12 one-way trips	24 one-way trips
Fitness	\$0	\$0	\$0
24/7 Nurse Line	\$0	\$0	\$0
Post-Discharge Meal Delivery	10 meals	10 meals	14 meals
Meals Support	Not covered	Not covered	Not covered
In-Home Support Services	Not covered	Not covered	60 hours/year
Personal Emergency Response System	\$0	\$0	\$0
Advance Care Planning Services	\$0	\$0	\$0

H3706-025 Generations Chronic Care Savings (HMO C-SNP)	H3706-028 Generations Dual Support (HMO D-SNP)	H3706-029 Generations Dual Premier (HMO D-SNP)	H3706-009 Generations Valor (HMO-POS)
\$1,000	\$2,000	\$2,000	\$1,000
\$2,000	\$3,000	\$4,000	\$1,500
\$200	\$300	\$400	\$300 combined in- and out-of-network
\$1,000/yr (Hearing, Dental and/or Vision); \$150/qtr (OTC and/or Groceries)	\$1,000/yr (Hearing, Dental and/or Vision); \$150/mo (OTC, Groceries and/or Utilities)	\$1,250/yr (Hearing, Dental and/or Vision); \$150/mo (OTC, Groceries and/or Utilities)	\$500/yr (Hearing, Dental and/or Vision); \$100/qtr (OTC)
24 one-way trips	36 one-way trips	36 one-way trips	24 one-way trips
\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0
14 meals	42 meals	42 meals	10 meals
Not covered	14 meals	14 meals	Not covered
60 hours/year	60 hours/year	60 hours/year	Not covered
\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0

Benefit limitations, prior authorizations, and/or referrals may apply. Please reference the plan’s Evidence of Coverage for a complete description of benefits.



# What does Maximum Out-of-Pocket (MOOP) mean?

The Maximum Out-of-Pocket (MOOP) is the limit of how much you pay when you share the cost of your care through deductibles, coinsurance and copays. What you pay toward Medicare Part A and Part B services, including your plan’s deductible, coinsurance and copays apply to your MOOP. What you pay toward supplemental benefits coinsurance and copays do not apply to your MOOP. Once you reach your MOOP, the plan pays 100% of the following services.

Our Generations Medicare Advantage Plans protect you with a LOW maximum out-of-pocket.

## Inpatient Services

- Inpatient Hospital Care
- Inpatient Mental Health
- Skilled Nursing Facility

## Outpatient Services

- Doctor Visits
- Chiropractic Services
- Podiatry Services
- Home Health Services
- Outpatient Mental Health
- Outpatient Substance Abuse
- Outpatient Surgery
- Medically Necessary Ambulance Services
- Emergency Care
- Urgent Care
- Outpatient Rehabilitation Services (OT, PT, & ST)

## Outpatient Medical Services & Supplies

- Annual Wellness Visit
- Durable Medical Equipment
- Prosthetic Devices
- Diabetes Self Monitoring & Training
- Diabetic Monitoring Supplies
- Nutrition Therapy & Supplies
- Diagnostic Tests
- X-Rays
- Lab Services
- Radiology Services
- Bone Mass Measurement
- Colorectal Screening Exams
- Immunizations (Flu, Hepatitis B, Pneumonia)
- Mammograms
- Pap Smears
- Prostate Cancer Screening Exams
- End Stage Renal Disease Services

# What is Smart Wallet?

GlobalHealth has partnered with NationsBenefits to give members the Smart Wallet, a Benefits Mastercard Prepaid Card. This card will hold a member’s annual and monthly/quarterly/annual allowances for Dental, Vision, Hearing, OTC, Groceries and/or Utilities. Please note all plans do not offer each category.

Members can see what’s eligible for purchase at [GlobalHealth.NationsBenefits.com](https://GlobalHealth.NationsBenefits.com). You may use your Smart Wallet at any of the following retail locations.

- Walmart
- OTC Catalog

Plan Name	Benefit Allowance	Frequency	Benefits and Programs
Generations Classic Rewards (HMO)	\$500	Annual	Dental, Vision and/or Hearing
Generations Classic Plus (HMO)	\$500	Annual	Dental, Vision and/or Hearing
Generations Chronic Care (HMO C-SNP)	\$1000	Annual	Dental, Vision and/or Hearing
Generations Chronic Care Savings (HMO C-SNP)	\$1000	Annual	Dental, Vision and/or Hearing
Generations Dual Support (HMO D-SNP)	\$1000	Annual	Dental, Vision and/or Hearing
Generations Dual Premier (HMO D-SNP)	\$1250	Annual	Dental, Vision and/or Hearing
Generations Valor (HMO)	\$500	Annual	Dental, Vision and/or Hearing

Plan Name	Benefit Allowance	Frequency	Benefits and Programs
Generations Classic Rewards (HMO)	\$100	Quarterly	OTC
Generations Classic Plus (HMO)	\$100	Quarterly	OTC
Generations Chronic Care (HMO C-SNP)	\$150	Quarterly	OTC, Groceries
Generations Chronic Care Savings (HMO C-SNP)	\$150	Quarterly	OTC, Groceries
Generations Dual Support (HMO D-SNP)	\$150	Monthly	OTC, Groceries and/or Utilities
Generations Dual Premier (HMO D-SNP)	\$150	Monthly	OTC, Groceries and/or Utilities
Generations Valor (HMO)	\$100	Quarterly	OTC

Members can also view allowances on the MyBenefits portal starting 1/1/2023. This portal allows members to:

- Access [www.GlobalHealth.com](http://www.GlobalHealth.com) to order online
- Activate and manage their card
- Check products and services eligibility
- View available balance and transaction history
- Update personal account information
- Search for retail location

Members can contact Customer Care

844-280-5555 (TTY:711)

Available 8am - 8pm  
7 days per week, October 1 - March 31,  
Monday - Friday, April 1 - September 30



## GlobalHealth Supplemental Benefits

GlobalHealth partners with great companies to provide vision, dental, hearing, transportation, fitness and over-the-counter benefits. When using these benefits, you must stay in the network of providers and take your GlobalHealth ID card to the participating network facility on your first visit or have it ready when you call. Check your plan’s EOC to verify coverage for the services below.



Dental – GlobalHealth partners with DentaQuest to provide dental services. To view a complete provider listing for DentaQuest, visit [www.GlobalHealth.com](http://www.GlobalHealth.com). For questions, please call 1-833-955-3423 (TTY: 800-466-7666) or contact Customer Care.





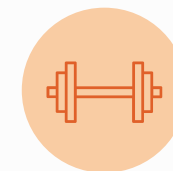
**Vision** – GlobalHealth partners with EyeMed to provide vision services. To view a complete provider listing for EyeMed, please visit [www.GlobalHealth.com](http://www.GlobalHealth.com). For questions, please call 1-800-884-6321 (TTY: 711) or contact Customer Care.



**Hearing** – NationsHearing provides hearing services to GlobalHealth members. To view a complete provider listing for NationsHearing, visit [www.GlobalHealth.com](http://www.GlobalHealth.com). You may also contact NationsHearing at 1-877-241-4736 (TTY: 711) or Customer Care for all hearing benefit questions.



**Transportation** – GlobalHealth partners with RoundTrip to provide transportation services. To schedule a ride to your doctor or other plan-approved location, call RoundTrip at 1-877-565-1612. 72 hours notice required.



**Fitness** – GlobalHealth offers a fitness benefit to all Medicare Advantage members. For a complete listing of participating network facilities and information on how to utilize all of the benefits visit [www.GlobalHealth.com](http://www.GlobalHealth.com) or contact 877-427-4788.



**Meal Delivery** – GlobalHealth partners with Independent Living Systems to help provide you meals after you are discharged from an inpatient hospital or skilled nursing facility admission. A GlobalHealth Case Manager will arrange your meal delivery.



**24/7 Nurse Line** – GlobalHealth's 24/7 nurse line is staffed with skilled, registered nurses ready to assist you with health concerns. Call 1-800-554-9371 (TTY: 711) for assistance.

For questions prior to January 1st, 2023, contact GlobalHealth's Customer Care.

Enrolling in a

## GlobalHealth Generations Medicare Advantage Plan

### 4 easy ways to submit your enrollment:



#### Call us:

To enroll by phone, please call us at 1-855-766-7881 (TTY: 711)\*.



#### Local sales agent:

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

FOR AGENT USE ONLY:

Agent Online Enrollment:

You have the option to enroll a member on our website:  
<https://globalhealth2.destinationrx.com/PC/2023>

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





#### Enroll online:

Go to <https://globalhealth1.destinationrx.com/PC/2023> to enroll.

Medicare beneficiaries may also enroll in a GlobalHealth Generations Medicare Advantage Plan through the CMS Online Enrollment Center located at: [www.Medicare.gov](http://www.Medicare.gov).

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

If you need assistance in filling out your enrollment form or have any questions, please call us at 1-855-766-7881 (TTY: 711)\*.



#### By Mail:

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

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

GlobalHealth  
Attn: Eligibility and Enrollment  
P.O. Box 1678  
Oklahoma City, OK 73101-1678

## Medicare

### Key Terms

**Coinsurance:** An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

**Copayment (copay):** An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

**Cost Share:** Refers to amounts that a member has to pay when services or drugs are received (for example, your copayment or coinsurance).

**C-SNP (Chronic Condition Special Needs Plan):** A Medicare Advantage plan designed for Medicare beneficiaries with chronic conditions such as heart disease. Plans may offer C-SNP plans for only one condition or a group of conditions.

**Deductible:** The amount you must pay for health care or prescriptions before the plan begins to pay.

**Drug Formulary:** A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Health Maintenance Organization – Point of Service (HMO-POS):** A Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing Plan Members to seek care outside of the traditional HMO network under certain situations or for certain treatment.

**Maximum Out-of-Pocket (MOOP):** The most that you pay out-of-pocket during the calendar year for covered services.

**Network:** Group of contracted providers, facilities and pharmacies for the plan.

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

**Prior Authorization:** For certain services or prescription drugs, you will need to get approval in advance from your insurance provider before obtaining the services or drugs. Your Primary Care Physician (PCP) or specialist may submit prior authorization to your insurance for the prior authorization.

# Important Phone Numbers

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



Important Numbers	Why Call
-------------------	----------

### Customer Care

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

8 am - 8 pm  
7 days a week (Oct 1 - Mar 31)  
Monday - Friday (Apr 1 - Sept 30)

### 24 Hour Nurse Line

1-800-554-9371

Speak to a Member Advocate:

- If you’ve lost important plan documents, like your Member ID card or your Summary of Benefits.
- If you need to obtain authorization for a service or procedure.
- If you need to know if a specific procedure or service is covered.
- If you have benefit or coverage questions.
- If you need help locating a network provider or pharmacy.
- If you need to verify if a prescription is on the drug formulary.

### Fraud, Waste, and Abuse Hotline

1-877-280-5852

All communications are confidential and anonymous.

Report any health care fraud, such as:

- Provider bills you for medical services, supplies or items that were not provided.
- Provider performs medically unnecessary services to obtain the insurance payment.
- Someone steals your personal information to submit false claims to obtain the insurance benefit.
- Someone pretends to represent Medicare, the Social Security Administration or an insurance plan for the purpose of obtaining personal information.

## Still Have Questions?

Get easy-to-understand answers to your Medicare questions.

Compare GlobalHealth’s Generations Medicare Advantage plans to your current plan.



Speak to a licensed agent

1-855-766-7881 | TTY: 711

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



Visit [www.GlobalHealthMedicare.com](http://www.GlobalHealthMedicare.com) to find plan information and helpful resources.

THE FOLLOWING PAGES  
ARE FOR AGENT USE ONLY



# Enrollment Form

## GlobalHealth, Inc. MA-MAPD Individual Enrollment Request Form

### Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

#### To join a plan, you must:

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

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

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

### When do I use this form?

You can join a plan:

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

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

### What do I need to complete this form?

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

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

### Reminders:

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

### What happens next?

Send your completed and signed form to:

#### By Mail:

GlobalHealth, Inc.  
P.O. Box 1678  
Oklahoma City, OK 73101

**By Fax:** 405-280-5455

**By Email:** ghmaenrollment@globalhealth.com

Once we process your request to join, we’ll contact you.

### How do I get help with this form?

Call GlobalHealth at 1-844-280-5555. TTY users can call 711.

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

**En español:** Llame a GlobalHealth al 1-844-280-5555/TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Phone: 1-844-280-5555 (TTY/TDD: 711)

Fax: 405-280-5455

Email: ghmaenrollment@globalhealth.com

www.GlobalHealth.com

GlobalHealth, Inc., P.O. Box 1678, Oklahoma City, OK 73101



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

Select the plan you want to join:

☐ Generations Classic Rewards (HMO):

\$0 per month

☐ Generations Valor (HMO-POS)\*:

\$0 per month

☐ Generations Classic Plus (HMO):

\$0 per month

☐ Generations Chronic Care (HMO C-SNP):

\$0 per month

☐ Generations Chronic Care Savings (HMO C-SNP):

\$0 per month

☐ Generations Dual Support (HMO D-SNP)\*\*:

\$0 per month

☐ Generations Dual Premier (HMO D-SNP)\*\*:

\$0 per month

\*(MA Only Plan, No Drug Coverage)

\*\*(For QMB and QMB full-benefit dual eligible only)

LAST name:

FIRST name:

(Optional) MI:

Birth date:

M

M

D

D

Y

Y

Y

Y

Sex:

☐ Male

☐ Female

Phone number:

Permanent Residence Street Address 1: (Don't enter a PO Box)

Street Number

Street Name

Lot/Apartment

City:

State:

Zip Code:

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

Street Number

Street Name

Lot/Apartment

City:

State:

Zip Code:

E-mail address (optional):

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage

☐ Formulary (List of Covered Drugs)

☐ Provider Directory

☐ Pharmacy Directory

☐ Summary of Benefits

Your Medicare information:

Medicare Number:

-

-

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to GlobalHealth?

☐ Yes

☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage:

Please choose the NAME of a Primary Care Physician (PCP), Clinic or Health Center:

PCP ID Number:

FIRST name:

MI:

LAST name:

Are you an existing patient of this PCP?

☐ Yes

☐ No

Dual Special Needs Plans Criteria: If you are applying for any one of the following plans, then please provide your Medicaid ID.

Medicaid ID#

• Generations Dual Support (HMO D-SNP)

• Generations Dual Premier(HMO D-SNP)

Chronic Special Needs Plans Criteria: If you are applying for any one of the following plans, then please fill out 'Chronic Special Needs Plan (SNP) Pre-Qualification Form' attached at the end of this Application Form.

• Generations Chronic Care (HMO C-SNP)

• Generations Chronic Care Savings(HMO C-SNP)

IMPORTANT: Read and sign below:

I must keep both Hospital (Part A) and Medical (Part B) to stay in GlobaHealth.

By joining this Medicare Advantage Plan, I acknowledge that GlobalHealth will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).

Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that when my GlobalHealth coverage begins, I must get all of my medical and prescription drug benefits from GlobalHealth. Benefits and services provided by GlobalHealth and contained in my GlobalHealth "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor GlobalHealth will pay for benefits or services that are not covered.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

1) This person is authorized under State law to complete this enrollment, and

2) Documentation of this authority is available upon request by Medicare.

Signature:

Today's date:

M

M

D

D

Y

Y

Y

Y

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

LAST name:

FIRST name:

(Optional) MI:

Permanent Residence Street Address:

Street Number

Street Name

Lot/Apartment

City:

State:

Zip Code:

Phone Number:

Relationship to Enrollee:

Section 2 - All fields below are optional

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

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

☐ Spanish

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

☐ Large print

☐ Braille

Please contact GlobalHealth at 1-844-280-5555 if you need information in an accessible format other than what's listed above. Our office hours are from October 1st to March 31st from 8 a.m. to 8 p.m. 7 days a week and from April 1st to September 30th from 8 a.m. to 8 p.m. Monday through Friday. TTY users can call 711.

Do you work?

☐ Yes

☐ No

Does your spouse work?

☐ Yes

☐ No

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, Not of Hispanic, Latino/a or Spanish Origin

☐ Yes, Cuban

☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Puerto Rican

☐ Yes, another Hispanic, Latino or Spanish Origin

☐ I choose not to answer

What's your race? Select all that apply.

☐ White☐ Black or African American☐ American Indian or Alaska Native☐ Native Hawaiian☐ Samoan☐ Other Pacific Islander

☐ Asian Indian☐ Chinese☐ Filipino☐ Japanese☐ Korean☐ Vietnamese☐ Other Asian☐ Guamanian or Chamorro

☐ I choose not to answer

H3706\_ENROLLMENTLONG\_2023\_M

- 2 of 6 -

<Form Number>

<b>Paying your plan premiums</b>	
<p><b>You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.</b></p> <p>If you don't select a payment option, you will get a bill each month.</p> <p><b>Please select a premium payment option:</b></p> <p><input type="checkbox"/> Get a bill.</p> <p>Automatic deduction from your monthly:</p> <p><input type="checkbox"/> Social Security benefit check, or  <input type="checkbox"/> Railroad Retirement Board (RRB) benefit check</p>	
<p><b>If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay GlobalHealth the Part D-IRMAA.</b></p>	
<b>OFFICE USE ONLY:</b>	
<b>Name of staff member/agent/broker (if assisted in enrollment):</b> _____	
Effective Date: (MM/DD/YYYY) <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Agent Signature: _____ Agent Received Date: <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div>
<div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Election Type: <input type="checkbox"/> ICEP/IEP <input type="checkbox"/> AEP <input type="checkbox"/> MA OEP <input type="checkbox"/> SEP(type) <div style="border: 1px solid black; width: 100px; height: 20px;"></div> <input type="checkbox"/> Not Eligible
Agency of Agent: _____ Current Insurance: _____	
Agent Name: (First) _____ <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	(Last) _____ <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
Agent ID#: _____ <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
<b>TR K-1</b> <input type="checkbox"/> Referral by Provider <input type="checkbox"/> Referred by Member <input type="checkbox"/> Company Website <input type="checkbox"/> Direct Mail <input type="checkbox"/> Self <input type="checkbox"/> Local Community Event <input type="checkbox"/> Media (TV, News Ad, Mag) <input type="checkbox"/> Seminar <input type="checkbox"/> Seminar Follow-up	
<b>TR K-2</b> <input type="checkbox"/> Personal Appt; Benefit Reply Card (SOA/BRC) <input type="checkbox"/> Walk-in (SOA) <input type="checkbox"/> Formal Event (Submit) <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
<input type="checkbox"/> Application Mailed by Beneficiary <input type="checkbox"/> Informal Event (SOA)	
Online/Telephonic Application Confirmation #: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
Date Received: _____	Member ID # _____

**PRIVACY ACT STATEMENT**

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

LEFT  
BLANK  
INTENTIONALLY



There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.

☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on:    /    /

☐ I was recently released from incarceration. I was released on:    /    /

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on:    /    /

☐ I recently obtained lawful presence status in the United States. I got this status on:    /    /

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on:    /    /

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on:    /    /

☐ I have both Medicare and Medicaid (or my state helps me pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on:    /    /

☐ I recently left a PACE program on:    /    /







## Pre-Enrollment Qualification Assessment Tool

Special Needs Plan (SNP) is a type of Medicare Advantage coordinated plan focused on individuals with special needs. Globalhealth offers Special Needs Plans (SNPs) designed for people with certain chronic or disabling conditions.

You may be eligible to join one of our chronic SNPs if you can answer YES to any of the questions below. Globalhealth will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. We are required to disenroll you from the special needs plan if we are unable to verify your chronic condition. It is very important that you let your doctor know that we will require their verification and that you provide us with accurate contact information for your doctor at the bottom of this form.

Chronic Heart Failure/Cardiovascular Disorder/Diabetes	
Has your doctor or other licensed health care professional diagnosed you with any of the following medical conditions? (Check all that apply)	
Chronic Heart Failure (CHF)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Heart Failure	
Do you have fluid in your lungs?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have swelling in your feet and legs almost every day because of too much fluid in your body?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take medicine for the fluid in your lungs or to help your heart beat stronger?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular Disorder	
Have you had a heart attack or been told by your doctor you are at risk to have one?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have heart pain (angina) or leg pain (claudication) brought on when you are active?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take medicine for your heart or circulation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	
Do you check your blood sugar at home?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have high blood sugar?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take medicine to control your blood sugar?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

## Beneficiary Information

Beneficiary Name:																																																											
Last Name:																				First Name:																				(Optional) MI:																			
<div></div>																				<div></div>																				<div></div>																			
Birth Date:																														Medicare ID Number (HICN):																													
M M / D D / Y Y Y Y																																																											
<div></div>																																																											
<p>I authorize the providers listed below to share my health information with GlobalHealth to verify that I have a chronic condition that qualifies me for enrollment in GlobalHealth’s chronic special needs plan. This authorization applies to all health information maintained by the provider concerning my medical history for the chronic condition(s) indicated on the first page. Note: GlobalHealth will protect information disclosed as a result of this authorization in accordance with any state and federal laws and requirements that apply. Call us if you have questions or need help with this form. You can reach us at 1-844-280-5555 (TTY: 711). Hours of operation are 8 a.m. to 8 p.m., seven days a week, (October 1 - March 31), and 8 a.m. to 8 p.m., Monday through Friday, (April 1 - September 30). Visit us at anytime at <a href="#">www.GlobalHealth.com/medicare</a>.</p>																																																											
Enrollee Signature:																														Today's Date: M M / D D / Y Y Y Y																													
<div></div>																														<div></div>																													
Name of your Doctor or Health Care Provider:																																																											
Last Name:																				First Name:																				(Optional) MI:																			
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Phone Number:																				Fax Phone Number:																																							
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## Scope of Sales Appointment Confirmation

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

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

☐

Medicare Advantage Plan (Part C only)

☐

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

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

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

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

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent’s Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:



### Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 844-280-5555 (TTY: 711), 8:00 a.m. to 8:00 p.m., 7 days a week (October 1 - March 31) and Monday - Friday (April 1- September 30).

Understanding the Benefits	
<input type="checkbox"/>	The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit <a href="http://www.GlobalHealth.com">www.GlobalHealth.com</a> or call 844-280-5555 (TTY: 711) to view a copy of the EOC.
<input type="checkbox"/>	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
<input type="checkbox"/>	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
<input type="checkbox"/>	Review the formulary to make sure your drugs are covered.
Understanding Important Rules	
<input type="checkbox"/>	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.If the plan in discussion includes a Part B buy-down or is a D-SNP, your Medicare Part B premium may be less than the standard premium.
<input type="checkbox"/>	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
<input type="checkbox"/>	Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
<input type="checkbox"/>	Our Generations Valor (HMO-POS) Plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.
<input type="checkbox"/>	Generations Chronic Care (HMO C-SNP) and Generations Chronic Care Savings (HMO C-SNP) are a chronic condition special needs plans (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
<input type="checkbox"/>	Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) are dual eligible special needs plans (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.



# Health Survey

Please complete this survey. The goal of this survey is to help us understand your health and specific health care needs so we can work together to help provide you the services to reach your health goal(s). Your answers **WILL NOT** affect your benefits. We may share your information with your primary care provider. If you have any questions regarding this please contact Customer Care - 1-844-280-5555 (TTY: 711) 8am - 8pm, 7 days a week (October 1 - March 31), 8am - 8pm, Monday - Friday (April 1 - September 30)

Date: \_\_\_\_\_ Agent name and ID (if agent assisted): \_\_\_\_\_

Name: \_\_\_\_\_ Gender: ☐ Male ☐ Female

DOB: \_\_\_\_\_ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Phone number: \_\_\_\_\_

Application/MemberID: \_\_\_\_\_

1. What is your race?	
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
<input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> I choose not to answer	
2. What is your Ethnicity?	
<input type="checkbox"/> Not Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, Chicano/a	
<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> I choose not to answer	
3. What is your primary language?	
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ <input type="checkbox"/> I choose not to answer	
4. Please check whether you have ever had or have been treated for any of the following Chronic Conditions:	
<input type="checkbox"/> Alzheimer’s Disease/Dementia <input type="checkbox"/> Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis)	
<input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis or Pain in Joints <input type="checkbox"/> Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COVID-19 <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Cardiovascular Disease/Cornary Artery Disease/Peripheral Vascular Disease <input type="checkbox"/> Depression/Mental Illness	
<input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Heart Problems/Heart Disease/Heart Attack <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> High Cholesterol/Triglycerides <input type="checkbox"/> Kidney Disease/Failure <input type="checkbox"/> Immune Disorder (HIV or AIDS)	
<input type="checkbox"/> Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD)	
<input type="checkbox"/> Neurodegenerative Disease (Parkinson’s/Huntington’s Disease) <input type="checkbox"/> Organ Transplant (Liver, Kidney, etc.)	
<input type="checkbox"/> Stroke	
5. Please check the following conditions you are currently experiencing or receiving medical treatment for:	
<input type="checkbox"/> Foot/Ankle/Leg Swelling <input type="checkbox"/> Sudden Increase in Weight or Overweight <input type="checkbox"/> Renal Dialysis	
<input type="checkbox"/> Open Sores, Wounds or Ulcers on Your Skin	
6. Health Care Access and Treatment:	
a. Do you have transportation to and from your medical appointments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physcial Exam or Wellness Visit in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Are you currently or have you ever been enrolled in hospice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. How many times have you been to the emergency room in the past 12 months?	<input type="checkbox"/> None <input type="checkbox"/> 1-3 times <input type="checkbox"/> More than 3
e. How many times have you been admitted to the hospital in the past 12 months?	<input type="checkbox"/> None <input type="checkbox"/> 1-3 times <input type="checkbox"/> More than 3
f. When was your last complete dilated eye exam?	<input type="checkbox"/> Never <input type="checkbox"/> Less than 12 months ago <input type="checkbox"/> More than 12 months ago

7. Activities of Daily Living:	
a. Do you need help with bathing or dressing yourself, preparing meals, feeding yourself, or using the bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you need help walking, getting up from a chair, or getting out of bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you need help taking your medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you currently use assistive devices or durable equipment (wheelchair, walker, cane, raised toilet seat, etc.) to walk, bathe, shower, or use the bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. In the past 12 months, how many times have you fallen whether in your home or at another location?	<input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> More than once
8. Behavioral and Social:	
a. In the past 12 months, have you felt sad, blue, or depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the past 12 months, have you experienced changes in thinking, remembering, or decision making?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does forgetfulness (such as forgetting to pay bills or take your medications) cause problems in your daily life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If you answered yes to Question D, would you like to receive information to help you quit smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Do you drink alcohol often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. In the last 12 months, have you used illegal drugs or substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. If you answered yes to Question G, would you like to receive information about controlling this problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Do you socialize with others regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Do you exercise regularly or at least several days a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Do you currently feel threatened or that you are being physically, mentally, or sexually abused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Do you experience feelings of stress in your life, like when handling things related to your health, finances, family or social relationships, work, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. In general, how would you rate your overall health?	<input type="checkbox"/> Excellent/Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
n. In the past 3 months, have you had difficulty meeting your living expenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Would you like to receive information regarding advanced directives or living wills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Do you have or need a caregiver to help you take care of your needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
q. What is the highest level of education you completed?	<input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> Vocational School <input type="checkbox"/> College
r. How well can you read?	<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> I Cannot Read
9. Medical Treatment/Vaccinations:	
a. How many different medications do you take every day?	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> More than 6
b. When was your last flu shot?	<input type="checkbox"/> Never <input type="checkbox"/> Within the last 12 months <input type="checkbox"/> More than 12 months ago
c. When was your last pneumonia shot?	<input type="checkbox"/> Never <input type="checkbox"/> Less than 10 years ago <input type="checkbox"/> More than 10 years ago
d. Have you received the COVID-19 vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If you have received the COVID-19 vaccinations, have you received the full vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No



**Multi-Language Insert**  
**Multi-language Interpreter Services**

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-280-5555. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-280-5555. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费~~的~~翻译服务，帮助您解答关于健康或~~药~~物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-280-5555。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-280-5555。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-280-5555. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-280-5555. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-844-280-5555 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelpplan. Unsere Dolmetscher erreichen Sie unter 1-844-280-5555. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-280-5555번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-280-5555. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول . سيقوم شخص ما يتحدث العربية1-844-280-5555على مترجم فوري، ليس عليك سوى الاتصال بنا على .بمساعتك. هذه خدمة مجانية

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-280-5555 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-280-5555. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-280-5555. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-280-5555. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-280-5555. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-280-5555にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

## Notes

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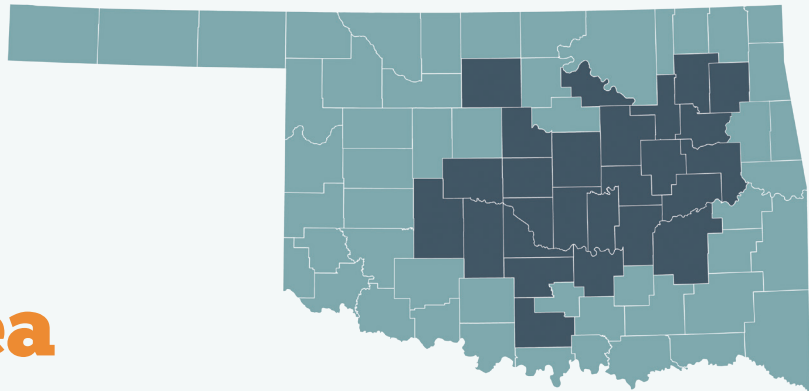
Medicare Advantage Plans

For questions or to enroll:

1-855-766-7881 (TTY: 711)

[www.GlobalHealthMedicare.com](http://www.GlobalHealthMedicare.com)

## 2023 Service Area



Caddo	Garvin	McClain	Pawnee	Tulsa
Canadian	Grady	McIntosh	Pittsburg	Wagoner
Carter	Hughes	Muskogee	Pontotoc	
Cleveland	Lincoln	Okfuskee	Pottawatomie	
Creek	Logan	Oklahoma	Rogers	
Garfield	Mayes	Okmulgee	Seminole	

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

You must continue to pay your Medicare Part B premium. By calling the listed number you may be speaking with a licensed sales representative.

Based on a Model of Care review, GlobalHealth has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2023.

Out-of-network/non-contracted providers are under no obligation to treat Generations Valor (HMO-POS) 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.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. GlobalHealth tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Fraud, Waste and Abuse: GlobalHealth is committed to fighting health care fraud, waste and abuse. If you suspect Medicare fraud, waste or abuse, call our hotline — 1-877-280-5852. Contact the plan for more information.