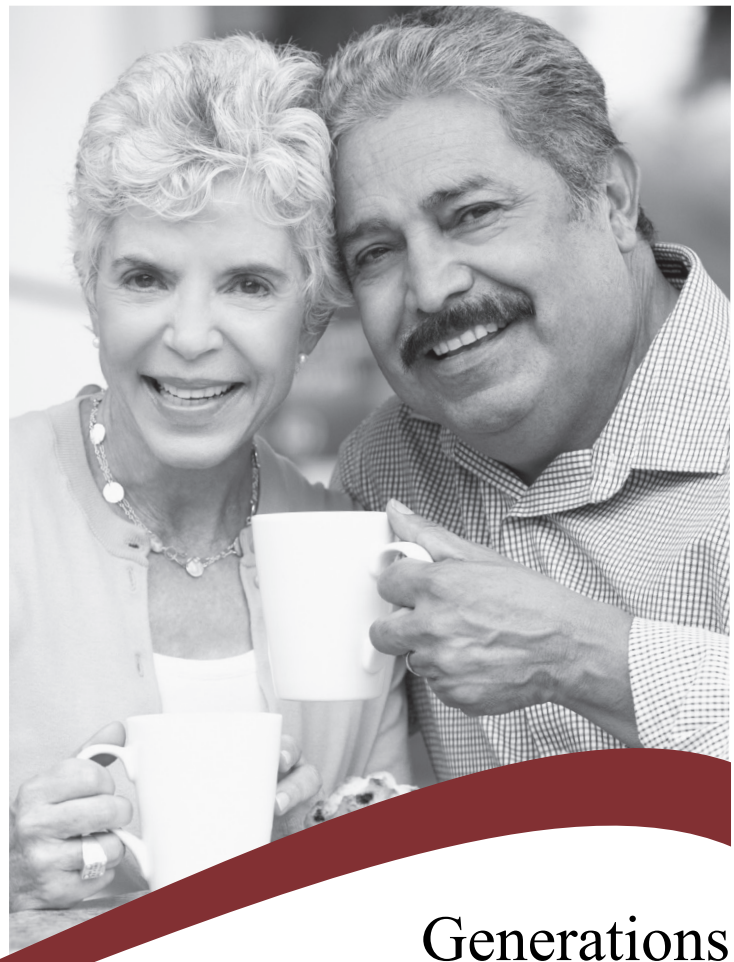
GlobalHealth



Annual Notice of Changes

January 1 - December 31, 2022

Generations Classic Choice (HMO-POS)

GlobalHealth is an HMO/HMO C-SNP plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.

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

H3706_CLASSICCHOICEANOC_2022_M

Generations Classic Choice (HMO-POS) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2022

You are currently enrolled as a member of Generations Classic Choice (HMO-POS). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.2 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: February 29, 2024)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ 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, 2021, you will be enrolled in Generations Classic Choice (HMO-POS).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Generations Classic Choice (HMO-POS).
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

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 a.m. to 8 p.m., 7 days a week, (October 1 – March 31), and 8 a.m. to 8 p.m., 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 Choice (HMO-POS)

- GlobalHealth is an HMO/HMO C-SNP plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal.
- When this booklet says "we," "us," or "our," it means GlobalHealth, Inc. When it says "plan" or "our plan," it means Generations Classic Choice (HMO-POS).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Generations Classic Choice (HMO-POS) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.GlobalHealth.com. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$10	$10
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 1.2 for details.)	$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, $10,000 for combined in-network and out-of-network covered services.
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $45 per visit	Primary care visits: $0 per visit Specialist visits: $45 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	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.	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.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share:	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail Cost-Share:

Cost	2021 (this year)	2022 (next year)
	• 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 Mailorder 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 Mailorder Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost	• 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 Mailorder 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 Mailorder Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost

Cost	2021 (this year)	2022 (next year)
	• Drug Tier 5: 33% of the total cost	• Drug Tier 5: 33% of the total cost
	Standard 90-day Retail Cost-Share:	Standard 100-day Retail Cost-Share:
	• Drug Tier 1: $30	• Drug Tier 1: $30
	• Drug Tier 2: $60	• Drug Tier 2: $60
	• Drug Tier 3: $141	• Drug Tier 3: $141
	• Drug Tier 4: 50% of the total cost	• Drug Tier 4: 50% of the total cost
	Preferred 90-day Retail Cost-Share:	Preferred 100-day Retail Cost-Share:
	• Drug Tier 1: $0	• Drug Tier 1: $0
	• Drug Tier 2: $0	• Drug Tier 2: $0
	• Drug Tier 3: $84	• Drug Tier 3: $84
	• Drug Tier 4: 40% of the total cost	• Drug Tier 4: 40% of the total cost
	Standard 90-day Mailorder Cost-Share:	Standard 100-day Mailorder Cost-Share:
	• Drug Tier 1: $30	• Drug Tier 1: $30
	• Drug Tier 2: $60	• Drug Tier 2: $60
	• Drug Tier 3: $141	• Drug Tier 3: $141
	• Drug Tier 4: 50% of the total cost	• Drug Tier 4: 50% of the total cost
	Preferred 90-day Mailorder Cost-Share:	Preferred 100-day Mailorder Cost-Share:
	• Drug Tier 1: $0	• Drug Tier 1: $0
	• Drug Tier 2: $0	• Drug Tier 2: $0
	• Drug Tier 3: $84	• Drug Tier 3: $84
	• Drug Tier 4: 40% of the total cost	• Drug Tier 4: 40% of the total cost

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SECTION 1 Changes to Benefit and Cost for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$10	$10

- 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 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2021 (this year)	2022 (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 plan premium and 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, $10,000 for combined in-network and out-of-network covered services. Once you have paid $3,900 out-of-pocket for in-network covered Part A and Part B services you will pay nothing for covered Part A and Part B services at in-network providers. Once you have paid $10,000 out-of-pocket for combined in-network and out-of-network covered services, you will pay nothing

Cost	2021 (this year)	2022 (next year)
		for your covered Part A and Part B services for either in-network or out-of-network covered services.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at www.GlobalHealth.com. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at www.GlobalHealth.com. You may also call Customer Care for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your 2022 *Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Acupuncture for chronic low back pain	In-network: Prior Authorization is not required.	In-network: Prior Authorization may be required.
Ambulance services	In-network: You pay a $250 copay for Medicare-covered ambulance services per one-way trip. Out-of-network: You pay 30% of the total cost.	In-network: You pay 20% of the total cost for Medicare-covered air ambulance per one-way trip. You pay a $250 copay for Medicare-covered ground ambulance services per one-way trip. Out-of-network: You pay 20% of the total cost.

Cost	2021 (this year)	2022 (next year)
Annual physical exam	Annual physical exam is not covered.	In-network: There is no coinsurance, copay, or deductible for annual physical exam. Out-of-network: Not covered.
COVID-19	Cost shares waived for treatment of COVID-19 even if public health emergency is lifted: • Emergency services • Inpatient hospital care • Medicare Part B prescription drugs • Observation services • Specialist visits • Skilled nursing facility • Urgently needed services	Cost shares not waived outside of public health emergency.
Dental services	In-network: You pay a $45 copay per office visit, $250 in ASC setting, and $320 in outpatient hospital setting.	In-network: You pay a $45 copay per office visit for Medicare-covered dental services.
Preventive dental services	In-network: • Cleaning combined with periodontic 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) There is no coinsurance, copay, or deductible for preventive services. We will only pay up to a total of $1,000 for preventive and comprehensive dental services	In-network: • 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) • Fluoride (for up to 2 every year) There is no coinsurance, copay, or deductible for preventive services. There is no coinsurance, copay, or deductible for periodontic

Cost	2021 (this year)	2022 (next year)
	per year. You pay the amount that exceeds this allowance. Out-of-network: Not covered.	cleaning, combined with preventive cleanings. We will only pay up to a total of $1,000 for preventive and comprehensive dental services per year. You pay the amount that exceeds this allowance. Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount. Out-of-network: Not covered.
Comprehensive dental services	In-network: We will only pay up to a total of $1,000 for preventive and non-preventive dental services per year. You pay the amount that exceeds this allowance. Out-of-network: Not covered.	In-network: We will only pay up to a total of $1,000 for preventive and comprehensive dental services per year. You pay the amount that exceeds this allowance. Coinsurance you pay for supplemental dental services does not count toward the maximum out-of-pocket amount. Any amount you pay above the plan allowance does not count toward the maximum out-of-pocket amount. Out-of-network: Not covered.
Worldwide coverage for emergency department services	Worldwide coverage for emergency department services is not covered.	You pay a $90 copay per visit for emergency services outside the United States and its territories. You are covered for up to $50,000 every year for emergency or urgently needed services (combined) outside the United States. Copays you pay for worldwide emergency services do not count toward the maximum

Cost	2021 (this year)	2022 (next year)
		out-of-pocket amount. Any amount you pay above the plan limitation does not count toward the maximum out-of-pocket amount.
Inpatient hospital care	In-network: For Medicare-covered hospital stays 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. A benefit period begins the day you are admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.	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.
Inpatient mental health care	In-network: For Medicare-covered hospital stays in a 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. A benefit period begins the day you are admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit	In-network: For each Medicare-covered hospital stay in a 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.

Cost	2021 (this year)	2022 (next year)
	period has ended, a new benefit period begins. There's no limit to the number of benefit periods.	
Meal benefit	In-network: If you have been diagnosed by a plan provider and meet certain criteria for the following: • Chronic obstructive pulmonary disease (COPD) • Coronary artery disease (CAD) • Diabetes • Heart failure • Hypertension • Blindness There is no coinsurance, copay, or deductible for eligible members. You are eligible for 10 meals following inpatient discharge, up to 4 times per year.	In-network: There is no disease state requirement. There is no coinsurance, copay, or deductible for the meal benefit. Limited to 2 meals per day for 5 days, for a total of 10 meals, up to 4 discharges per year.
Nurse line	Nurse line is not covered.	In-network: There is no coinsurance, copay, or deductible for nurse line visits. Out-of-network: Not covered.
Outpatient hospital observation	In-network: Prior authorization is not required. Out-of-network: Prior authorization is required.	In-network: Prior authorization may be required. Out-of-network: Prior authorization may be required.

Cost	2021 (this year)	2022 (next year)
Outpatient hospital services - observation services	In-network: Prior authorization is not required. Out-of-network: Prior authorization is required.	In-network: Prior authorization may be required. Out-of-network: Prior authorization may be required.
Outpatient mental health care	In-network: There is no coinsurance, copay, or deductible for supplemental telehealth counseling.	In-network: Supplemental telehealth is not covered.
Outpatient substance abuse services	In-network:There is no coinsurance, copay, or deductible for supplemental telehealth counseling.	In-network:Supplemental telehealth is not covered.
Prescription drugs - additional gap coverage	For Tier 1 generic drugs and Tier 3 generic oral antidiabetic medications, you pay either the same copay as in the Initial Coverage Stage or 25% of the costs, whichever is lower. For Tier 1 brand name drugs and Tier 3 brand name oral antidiabetic medications, the Manufacturer's Drug Discount amount of 70% is applied to the Initial Coverage Stage copay.	For Tier 1 generic drugs and Tier 3 generic oral antidiabetic medications, you pay the same copay as in the Initial Coverage Stage. For Tier 1 brand name drugs and Tier 3 brand name oral antidiabetic medications, the Manufacturer's Drug Discount amount of 70% is applied to the Initial Coverage Stage copay.
Transportation	In-network: If you have been diagnosed by a plan provider and meet certain criteria for the following: • Chronic obstructive pulmonary disease (COPD) • Coronary artery disease (CAD) • Diabetes • Heart failure	In-network: There is no disease state requirement. Non-emergency ground transportation in order to obtain medically necessary care and services under the plan's benefits. • Plan-approved locations limited to: ◦ Doctor office visits ◦ Lab appointments

Cost	2021 (this year)	2022 (next year)
	• Hypertension • Blindness Our case management team will arrange for your transportation. There is no coinsurance, copay, or deductible for eligible members. You are eligible for 12 one-way trips to and from doctor appointments.	◦ Chemo/radiation/ dialysis appointments ◦ Outpatient hospital visits ◦ Outpatient preventive service appointments • Trips are limited to 12 one-way trips per year – a round-trip counts as 2 one-way trips • Trips are limited to 50 miles, one-way You may arrange for your transportation through RoundTrip. There is no coinsurance, copay, or deductible. Any amount you pay for rides beyond the trip or location limitation does not count toward the maximum out-of-pocket amount.
Wigs for hair loss related to chemotherapy	In-network: We will only pay up to a total of $150 for wig(s) for hair loss related to chemotherapy per year. If the wig(s) you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. Prior authorization is required. Out-of-network: Not covered.	Wigs for hair loss related to chemotherapy is not covered.
Worldwide coverage for urgently needed services	Worldwide coverage for urgently needed services is not covered.	You pay a $90 copay per visit for urgently needed services outside the United States and its territories.

Cost	2021 (this year)	2022 (next year)
		You are covered for up to $50,000 every year for emergency or urgently needed services (combined) outside the United States. Copays you pay for worldwide urgently needed care services do not count toward the maximum out-of-pocket amount. Any amount you pay above the plan limitation does not count toward the maximum out-of-pocket amount.

Section 1.6 – 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.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Care.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions do not continue from year to year. You will need to submit a new request for formulary exceptions each year.

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.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

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. Because you receive "Extra Help" if you haven't received this insert by September 30, 2021, please call Customer Care and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.GlobalHealth.com. You can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

	2021 (this year)	2022 (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 $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:**

	2021 (this year)	2022 (next year)
	You pay 33% of the total cost. _____ Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).	*Standard cost sharing:* You pay 33% of the total cost. *Preferred cost sharing:* 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).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Explanation of Benefits notices	You receive notices from GlobalHealth and CVS.	You receive a notice from GlobalHealth, CVS and administrative partners.
Long-term supply of a drug	A long-term supply is up to a 90-day supply.	A long-term supply is up to a 100-day supply if a provider prescribes as a 100-day supply.
Payment methods	You may pay your premium by: • Direct bill • Bank draft • Credit/debit card	You may pay your premium by: • Direct bill • Social Security check withholding

Description	2021 (this year)	2022 (next year)
	• Social Security check withholding	
PCP changes	Changes are effective immediately.	Changes are effective the first of the following month.
Service area reduction	Adair, Alfalfa, Atoka, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Cleveland, Cotton, Craig, Creek, Custer, Dewey, Garfield, Garvin, Grady, Grant, Haskell, Hughes, Jefferson, Kingfisher, Kiowa, Lincoln, Logan, Love, Major, Mayes, McClain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Rogers, Seminole, Stephens, Tillman, Tulsa, Wagoner, Woods	Cleveland, Creek, Lincoln, Oklahoma, Pottawatomie, Rogers, Tulsa
Vision	Routine eye exam: You must use a network provider. Routine and post-cataract eyewear: You may go to any eyewear provider.	Routine eye exam: You must use an EyeMed network provider. Routine and post-cataract eyewear: You must go to an EyeMed network provider.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Generations Classic Choice (HMO-POS)

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 Choice (HMO-POS).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

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 Choice (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Classic Choice (HMO-POS).
- 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 this (phone numbers are in Section 7.1 of this booklet).
  - – *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 4 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, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

Senior Health Insurance Counseling Program is independent (not connected with any insurance company or health plan). 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 6 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. Many people are eligible and don't even know it. 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 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); 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 (405) 426-8400.

SECTION 7 Questions?

Section 7.1 – Getting Help from Generations Classic Choice (HMO-POS)

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 a.m. to 8 p.m., 7 days a week, (October 1 – March 31), and 8 a.m. to 8 p.m., Monday – Friday, (April 1 – September 30). Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Generations Classic Choice (HMO-POS). 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 can also review the *Evidence of Coverage* to see if other benefit or cost changes affect you. 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 7.2 – 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

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the 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 booklet, you can get it at the Medicare website (www.medicare.gov) 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.

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