GlobalHealth

Oklahoma

SUMMARY OF BENEFITS

January 1-December 31, 2024

Generations Medicare Advantage Plan Options:

Generations Classic Rewards (HMO)
Generations Classic Plus (HMO)
Generations Valor (HMO-POS)

1-844-280-5555 (toll-free)
8 am to 8 pm, 7 days a week, (October 1 – March 31), and 8 am to 8 pm, Monday – Friday, (April 1 – September 30)
www.GlobalHealth.com

H3706_017_SBCORE2024_M

Generations Medicare Advantage Plans

Summary of Benefits

January 1, 2024 – December 31, 2024

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

To join GlobalHealth, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

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

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Monthly Plan Premium (You must continue to pay your Part B premium)	$0	$0	$0
Medicare Part B Premium Buydown	$75 per month	$0 per month	$75 per month
Deductible	$0	$0	$0
Maximum Out-of-Pocket (MOOP) Responsibility (Does not include supplemental benefits or prescription drugs)	$3,900	$3,900	$3,900 in-network; $4,900 combined in- and out-of-network
PART C BENEFITS			
Inpatient Hospital Coverage[1,2]	• $295 copay per day (Days 1 - 7); • $0 copay per day (Days 8 - 90)	• $245 copay per day (Days 1 - 7); • $0 copay per day (Days 8 - 90)	$295 copay per day (Days 1-7) in-network; $345 copay per day (Days 1-7) out-of-network $0 copay per day (Days 8 - 90)
Outpatient Hospital Surgery[1,2]	$320 copay per visit	$275 copay per visit	$320 copay per visit
Ambulatory Surgery Center[1,2]	$250 copay per visit	$225 copay per visit	$250 copay per visit

1 = Prior Authorization Required
2 = Referral Required

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Doctor Visits	• $0 copay per visit for PCP • $40 copay per visit for specialists[1,2]	• $0 copay per visit for PCP • $30 copay per visit for specialists[1,2]	• $0 copay per visit for PCP • $35 copay per visit for in-network specialists visits[1,2] • $55 copay per visit for out-of-network specialist visits[1,2]
Preventive Services	$0 for Medicare-covered preventive services	$0 for Medicare-covered preventive services	$0 for Medicare-covered preventive services
Emergency Care	$90 copay per visit; waived if admitted to acute care	$90 copay per visit; waived if admitted to acute care	$90 copay per visit; waived if admitted to acute care
Urgently Needed Services	$30 copay per visit	$30 copay per visit	$15 copay per visit
Outpatient Labs, X-Rays, Etc.	$0 copay for labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	$0 copay for labs, x-rays, ultrasounds, EKGs, and similar low-cost diagnostics	• $5 copay for labs • $0 copay for x-rays, ultrasounds, EKGs and similar low-cost diagnostics
Outpatient Diagnostic Radiology (MRI, etc.)[1,2]	• $180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility • $250 copay per visit in outpatient hospital	• $180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility • $275 copay per visit in outpatient hospital	• $180 copay per visit in PCP, specialist, urgent care, freestanding radiological facility • $250 copay per visit in outpatient hospital

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2 = Referral Required

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Hearing Services	• $0 copay per visit for Medicare-covered services in a PCP office • $40 for Medicare-covered services in a specialist office • $0 copay for routine hearing exam limited to one per year • $0 copay for routine hearing aid evaluation limited to one per year • Our plan pays up to a total of $1,000 for hearing aids per year	• $0 copay per visit for Medicare-covered services in a PCP office • $30 for Medicare-covered services in a specialist office • $0 copay for routine hearing exam limited to one per year • $0 copay for routine hearing aid evaluation limited to one per year • Our plan pays up to a total of $1,000 for hearing aids per year	• $0 copay per visit for Medicare-covered services in a PCP office • $35 for Medicare-covered services in a specialist office • $0 copay for routine hearing exam limited to one per year • $0 copay for routine hearing aid evaluation limited to one per year • Our plan pays up to a total of $1,000 for hearing aids per year
Dental Services (Coinsurance for comprehensive services does not accumulate to MOOP)	• $40 for Medicare-covered services[1,2] • $0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments • Our plan pays a total of $1,500 for comprehensive dental services per year • 20% coinsurance for some comprehensive services	• $30 for Medicare-covered services[1,2] • $0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments • Our plan pays a total of $2,000 for comprehensive dental services per year • 20% coinsurance for some comprehensive services	• $35 for Medicare-covered services[1,2] • $0 copay for preventive services - oral exams, x-rays, cleanings, and fluoride treatments • Our plan pays a total of $1,500 for comprehensive dental services per year • 20% coinsurance for some comprehensive services
Vision Services	• $0 copay per visit for Medicare-covered services • $0 copay for routine eye exam limited to 1 per year • Our plan pays up to a total of $200 for all supplemental eyewear per year	• $30 copay per visit for Medicare-covered services • $0 copay for routine eye exam limited to 1 per year • Our plan pays up to a total of $200 for all supplemental eyewear per year	• $0 copay per visit for Medicare-covered services • $0 copay for routine eye exam limited to 1 per year • Our plan pays up to a total of $300 for all supplemental eyewear per year

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Inpatient Mental Health Care[1,2]	• $295 copay per day (Days 1-7); • $0 copay per day (Days 8-90)	• $245 copay per day (Days 1-7); • $0 copay per day (Days 8-90)	• $295 copay per day (Days 1-7) in-network; • $345 copay per day (Days 1-7) out-of-network; • $0 copay per day (Days 8-90)
Outpatient Mental Health Visit[1,2]	$0 copay per visit	$30 copay per visit	$0 copay per visit
PART D DRUGS **Cost-sharing may differ depending on the pharmacy type or status (e.g., preferred, standard, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g., 30- or 100-day supply). For more information on specific cost-sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online. PLEASE NOTE: Please visit our website for the most up-to-date "Drug List". The "Drug List" and/or pharmacy network may change at any time. You will receive notice when necessary.** **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.**			
Phase 1: Deductible	$0	$0	Not covered
Phase 2: Initial Coverage Limit (ICL)	$5,030	$5,030	Not covered
Tier 1: Preferred Generics (Preferred Retail 30-Day Supply)	$0 copay per fill	$0 copay per fill	Not covered
Tier 2: Generic (Preferred Retail 30-Day Supply)	$10 copay per fill	$10 copay per fill	Not covered

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	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Tier 3: Preferred Brand (Preferred Retail 30-Day Supply)	• $42 copay per fill • $35 copay per fill for insulins	• $42 copay per fill • $35 copay per fill for insulins	Not covered
Tier 4: Non-Preferred Drug (Preferred Retail 30-Day Supply)	• $90 copay per fill • $35 copay per fill for insulins	• $90 copay per fill • $35 copay per fill for insulins	Not covered
Tier 5: Specialty Tier (Preferred Retail 30-Day Supply)	• 33% of the cost per fill • $35 copay per fill for insulins	• 33% of the cost per fill • $35 copay per fill for insulins	Not covered
Tier 1: (Preferred Retail & Mail Order 100-Day Supply)	$0 copay per fill	$0 copay per fill	Not covered
Tier 2: (Preferred Retail & Mail Order 100-Day Supply)	$0 copay per fill	$0 copay per fill	Not covered
Tier 3: (Preferred Retail & Mail Order 100-Day Supply)	• $84 copay per fill • $84 copay per fill for insulins	• $84 copay per fill • $84 copay per fill for insulins	Not covered
Tier 4: Non-Preferred Drug (Preferred Retail and Mail Order 100-Day-Supply)	• $270 copay per fill • $105 copay per fill for insulins	• $270 copay per fill • $105 copay per fill for insulins	Not covered

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Phase 3 Coverage Gap Stage[4] (After your prescription costs reach $5,030)	**Generic Drugs:** • GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs. • Members pay 25% of the cost for other generic drugs. **Brand Name Drugs:** • The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. • Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs. **Insulins:** • Members pay no more than $35 for a 30-day supply of insulin.	**Generic Drugs:** • GlobalHealth members continue to pay the same amount as in the initial coverage stage for Tier 1 generic drugs. • Members pay 25% of the cost for other generic drugs. **Brand Name Drugs:** • The Medicare Coverage Gap Discount Program of 70% is applied to the initial coverage stage copayment for Tier 1 brand drugs or for Tier 3 oral antidiabetics. • Members pay 25% of the cost of the drug plus a portion of the dispensing fee for other brand name drugs. **Insulins:** • Members pay no more than $35 for a 30-day supply of insulin.	Not covered
4: Catastrophic Coverage Stage (After you have paid $8,000 out-of-pocket)	$0 copay per fill	$0 copay per fill	Not covered

4 = You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $8,000. This amount and rules for counting costs toward this amount have been set by Medicare.

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
OTHER PART C BENEFITS			
Outpatient Hospital Observation Services[1,2]	$300 copay per visit	$275 copay per visit	$300 copay per visit
Skilled Nursing Facility (SNF)[1,2]	• $0 copay per day (Days 1-20); • $184 copay per day (Days 21-100)	• $0 copay per day (Days 1-20); • $184 copay per day (Days 21-100)	• $0 copay per day (Days 1-20); $184 copay per day (Days 21-100) in-network; • $225 copay per day (Days 1-25); $0 copay per day (Days 26-100) out-of-network
Ambulance (One-way trip - waived if admitted to acute care) Non-emergency transport[1,2]	• $250 per occurrence for ground • You pay 20% of the cost per occurrence for air	• $250 per occurrence for ground • You pay 20% of the cost per occurrence for air	• $240 per occurrence for ground • You pay 20% of the cost per occurrence for air
Outpatient Rehabilitation Services[1,2] (Physical, occupational, and/or speech therapy)	$20 copay per visit	$30 copay per visit	$20 copay per visit

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	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Medicare Part B Drugs (Includes chemotherapy and Part B insulin)[1,2,3]	You pay up to 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service. This applies to specific Part B drugs and may include chemotherapy drugs. You will pay no more than $35 for a one-month's supply of Part B insulin. This applies to insulin used in an insulin pump.	You pay up to 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service. This applies to specific Part B drugs and may include chemotherapy drugs. You will pay no more than $35 for a one-month's supply of Part B insulin. This applies to insulin used in an insulin pump.	You pay up to 20% of the cost You will pay no more than the dollar amount of the adjusted coinsurance percentage that applies to the specific Part B rebatable drug (typically a single source drug, e.g., brand drug) based on the date of service. This applies to specific Part B drugs and may include chemotherapy drugs. You will pay no more than $35 for a one-month's supply of Part B insulin. This applies to insulin used in an insulin pump.
Chiropractic Services (Medicare-covered)	$20 copay per visit	$20 copay per visit	$20 copay per visit
Podiatry Services (Medicare-covered)[1,2]	$40 copay per visit	$30 copay per visit	$35 copay per visit
Acupuncture[1,2]	$25 copay per visit	$30 copay per visit	$25 copay per visit
Home Health Services[1,2]	$0 copay per visit	$0 copay per visit	$0 copay per visit
Durable Medical Equipment[1] (e.g., wheelchairs, oxygen)	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic Testing Supplies[1]	$0 copay	$0 copay	$0 copay

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3 = May be subject to Part B step therapy

	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Prosthetics and Related Supplies[1] (e.g., Braces, artificial limbs)	• $0 copay for surgically implanted devices and medical supplies • 20% coinsurance for external devices and medical supplies	• $0 copay for surgically implanted devices and medical supplies • 20% coinsurance for external devices and medical supplies	• $0 copay for surgically implanted devices and medical supplies • 20% coinsurance for external devices and medical supplies
Outpatient Therapeutic Radiology[1,2]	$50 copay per visit	$50 copay per visit	$50 copay per visit
SUPPLEMENTAL BENEFITS			
Smart Wallet (OTC Benefit includes nicotine replacement therapy)	• $500 per year for Hearing, Dental and/or Vision • $115 per quarter for Over-the-Counter	• $500 per year for Hearing, Dental and/or Vision • $115 per quarter for Over-the-Counter	• $500 per year for Hearing, Dental and/or Vision • $100 per quarter for Over-the-Counter
Transportation (To and from plan-approved locations)	$0 copay per one-way trip • Limited to 12 one-way trips per year • Limited to 50 miles per one-way trip	$0 copay per one-way trip • Limited to 12 one-way trips per year • Limited to 50 miles per one-way trip	$0 copay per one-way trip • Limited to 24 one-way trips per year • Limited to 50 miles per one-way trip
Fitness	$0 copay per visit	$0 copay per visit	$0 copay per visit
24/7 Nurse Line	$0 copay per visit	$0 copay per visit	$0 copay per visit
Meal Delivery[1]	$0 copay per meal • Limited to 10 meals following inpatient hospital or skilled nursing facility discharge • Limited to 4 times per year	$0 copay per meal • Limited to 10 meals following inpatient hospital or skilled nursing facility discharge • Limited to 4 times per year	$0 copay per meal • Limited to 10 meals following inpatient hospital or skilled nursing facility discharge • Limited to 4 times per year
Home Support Services	30 hours per year	30 hours per year	30 hours per year

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	Generations Classic Rewards (HMO)	Generations Classic Plus (HMO)	Generations Valor (HMO-POS)
Worldwide Emergency Care (Does not accumulate to MOOP)	• $90 copay per visit • Limited to $50,000 benefit combined with urgent care	• $90 copay per visit • Limited to $50,000 benefit combined with urgent care	• $90 copay per visit • Limited to $50,000 benefit combined with urgent care
Worldwide Urgent Care (Does not accumulate to MOOP)	• $90 copay per visit • Limited to $50,000 benefit combined with emergency care	• $90 copay per visit • Limited to $50,000 benefit combined with emergency care	• $90 copay per visit • Limited to $50,000 benefit combined with emergency care

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

For coverage and costs of Original Medicare, look in your current "**Medicare & You 2024**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

You can see the complete plan *Drug Formulary* (list of Part D prescription drugs) and any restrictions as well as the *Provider Directory* and the *Pharmacy Directory* on our website.

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

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 (toll-free) (TTY: 711). 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 (toll-free) (TTY: 711). 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 (toll-free) (TTY: 711)。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 (toll-free) (TTY: 711)。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 (toll-free) (TTY: 711). 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 (toll-free) (TTY: 711). 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 quí vị cần thông dịch viên xin gọi 1-844-280-5555 (toll-free) (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-280-5555 (toll-free) (TTY: 711). 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 1-844-280-5555 (toll-free) (TTY: 711)번으로 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 (toll-free) (TTY: 711). 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. سيقوم (toll-free) (TTY: 711) 1-844-280-5555 للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على شخص ما يتحدث العربية بمساعدتك. 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 (toll-free) (TTY: 711) 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 (toll-free) (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

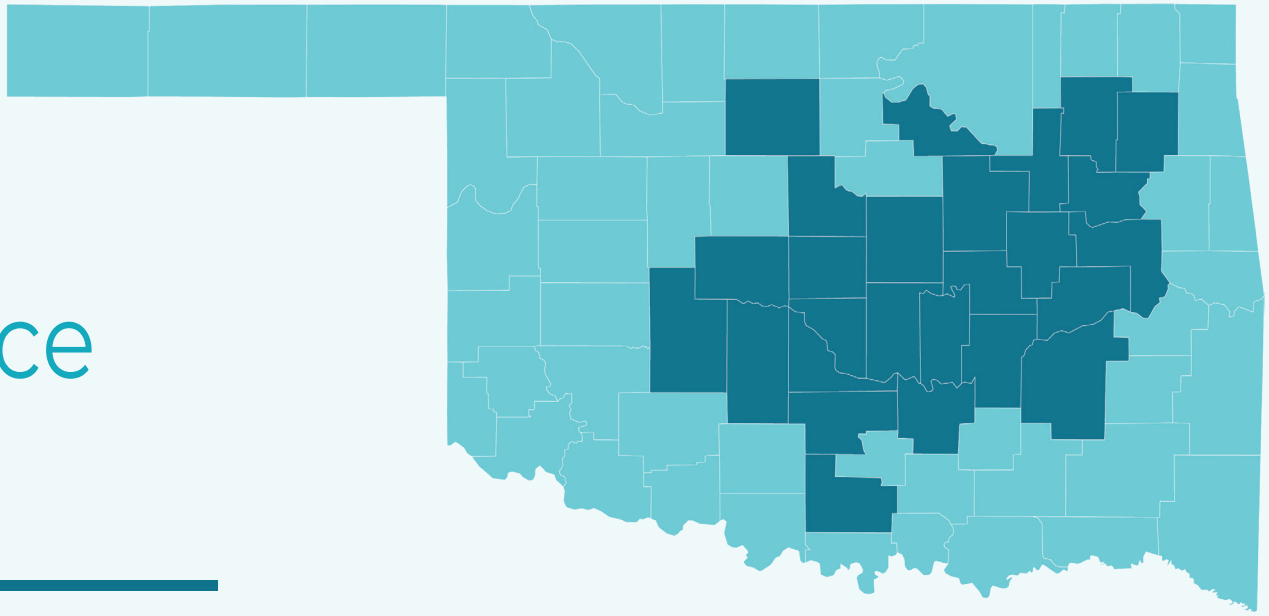
Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-280-5555 (toll-free) (TTY: 711). Irá encontrar alguém que fale o idioma Português para 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 (toll-free) (TTY: 711). 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 (toll-free) (TTY: 711). 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 (toll-free) (TTY: 711) 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。

2024 Service Area



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

GlobalHealth
MEDICARE ADVANTAGE PLANS

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

By calling the listed number you may be speaking with a licensed sales representative. Fraud, Waste and Abuse: GlobalHealth is committed to fighting healthcare fraud, waste and abuse. If you suspect Medicare fraud, waste or abuse, call our hotline — 1-877-627-0004. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.