Generations Healthcare HMO

A GlobalHealth Company

# 2016 Summary of Benefits

January 1 – December 31, 2016

## Generations Healthcare Classic (HMO)

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

1-844-280-5555 (TTY users call 711)
8 a.m. to 8 p.m., 7 days a week
www.GlobalHealth.com/Generations

H3706_SBMAPD_2016 Accepted

# Section I
# Introduction to Summary of Benefits

January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

**You Have Choices About How to Get Your Medicare Benefits.**

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Generations Healthcare Classic (HMO)**).

**Tips for Comparing Your Medicare Choices**

This Summary of Benefits booklet gives you a summary of what **Generations Healthcare Classic (HMO)** covers and what you pay.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.Medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.Medicare.gov or get a copy 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.

**Sections in This Booklet**

- Things to Know About **Generations Healthcare Classic (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

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

This document may be available in a non-English language. For additional information, call us at 1-844-280-5555.

**Things to Know About Generations Healthcare Classic (HMO)**

**Hours of Operation:**

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday from 8:00 a.m. to 8:00 p.m. Central time, Tuesday from 8:00 a.m. to 8:00 p.m. Central time, Wednesday from 8:00 a.m. to 8:00 p.m. Central time, Thursday from 8:00 a.m. to 8:00 p.m. Central time, Friday from 8:00 a.m. to 8:00 p.m. Central time, Saturday from 8:00 a.m. to 8:00 p.m. Central time.

**Generations Healthcare Classic (HMO) and Phone Numbers and Website:**

- If you are a member of this plan, call toll-

free 1-844-280-5555.

- If you are not a member of this plan, call toll free 1-844-280-5555.
- Our website: http://www.globalhealth.com/generations

**Who Can Join?**

To join **Generations Healthcare Classic (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Oklahoma: Adair, Alfalfa, Canadian, Cherokee, Cleveland, Craig, Creek, Garvin, Grady, Grant, Haskell, Kingfisher, Lincoln, Logan, Major, Mayes, McClain, McIntosh, Muskogee, Noble, Okfuskee, Oklahoma, Osage, Pawnee, Pottawatomie, Seminole, and Tulsa.

**Which Doctors, Hospitals, and Pharmacies Can I Use?**

**Generations Healthcare Classic (HMO)** has a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directories at our website (www.globalhealth-medicare.com/search.aspx Or, call us and we will send you a copy of the provider and pharmacy directories.

**What Do We Cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is co*vered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.globalhealth.com/generations_materials.aspx.
- Or, call us and we will send you a copy of the formulary.

**How Will I Determine My Drug Costs?**

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

# Section II
# Summary of Benefits

| | Generations Healthcare Classic (HMO) |
|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | |
| **How much is the monthly premium?** | **$0 per month.** In addition, you must keep paying your Medicare Part B premium. |
| **How much is the deductible?** | This plan does not have a deductible. |
| **Is there any limit on how much I will pay for my covered services?** | **Yes.** Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br>Your yearly limit(s) in this plan:<br>• **$3,300** for services you receive from in-network providers.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| **Is there a limit on how much the plan will pay?** | No. There are no limits on how much our plan will pay. |
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | |
| Note:<br>• Services with a [1] may require prior authorization.<br>• Services with a [2] may require a referral from your doctor. | |
| **OUTPATIENT CARE AND SERVICES** | |
| **Acupuncture** | Not covered |
| **Ambulance** | **$100 Copay** |

| | Generations Healthcare Classic (HMO) |
|---|---|
| **Chiropractic Care** | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): **$20 copay** |
| **Dental Services** | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **$40 copay**<br>**Preventive dental services:**<br>• Cleaning (for up to 2 every year): **You pay nothing**<br>• Dental x-ray(s) (for up to 2 every year): **You pay nothing**<br>• Oral exam (for up to 2 every year): **$5 copay** |
| **Diabetes Supplies and Services**[1,2] | Diabetes monitoring supplies: **0-20% of the cost,** depending on the supply<br>Diabetes self-management training: **You pay nothing**<br>Therapeutic shoes or inserts: **20% of the cost** |
| **Diagnostic Tests, Lab and Radiology Services, and X-Rays**<br>*(Costs for these services may be different if received in an outpatient surgery setting)*[1,2] | Diagnostic radiology services (such as MRIs, CT scans): **20% of the cost**<br>Diagnostic tests and procedures: **20% of the cost**<br>Lab services: **20% of the cost**<br>Outpatient x-rays: **20% of the cost**<br>Therapeutic radiology services (such as radiation treatment for cancer): **20% of the cost** |
| **Doctor's Office Visits**[1,2] | Primary care physician visit: **You pay nothing**<br>Specialist visit: **$40 copay** |
| **Durable Medical Equipment** *(wheelchairs, oxygen, etc.)*[1] | **20% of the cost** |
| **Emergency Care** | **$75 copay**<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Foot Care** *(podiatry services)*[1,2] | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: **$40 copay** |

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|---|---|
| **Hearing Services**[1,2] | Exam to diagnose and treat hearing and balance issues: **$40 copay** |
| **Home Health Care**[1,2] | **You pay nothing** |
| **Mental Health Care**[1,2] | **Inpatient visit:**<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.<br>Our plan **covers 90 days** for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>• **$279 copay** per day for days 1 through 6<br>• **You pay nothing** per day for days 7 through 90<br>Outpatient group therapy visit: **$40 copay**<br>Outpatient individual therapy visit: **$40 copay** |
| **Outpatient Rehabilitation**[1,2] | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): **$40 copay**<br>Occupational therapy visit: **$40 copay**<br>Physical therapy and speech and language therapy visit: **$40 copay** |
| **Outpatient Substance Abuse**[1,2] | Group therapy visit: **$40 copay**<br>Individual therapy visit: **$40 copay** |
| **Outpatient Surgery**[1,2] | Ambulatory surgical center: **$250 copay**<br>Outpatient hospital: **$320 copay** |

| | Generations Healthcare Classic (HMO) |
|---|---|
| **Over-the-Counter Items** | Not Covered |
| **Prosthetic Devices** *(braces, artificial limbs, etc.)*[1] | Prosthetic devices: **20% of the cost**<br>Related medical supplies: **20% of the cost** |
| **Renal Dialysis**[1,2] | **20% of the cost** |
| **Transportation** | Not Covered |
| **Urgently Needed Services** | **$30 copay**<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Vision Services**[1] | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): **You pay nothing**<br>Routine eye exam (for up to 1 every year): **You pay nothing**<br>Eyeglasses or contact lenses after cataract surgery: **20% of the cost** |
| **Preventive Care** | **You pay nothing**<br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening |

| | Generations Healthcare Classic (HMO) |
|---|---|
| **Preventive Care**<br>*continued* | • Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Hospice** | **You pay nothing** for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. |
| INPATIENT CARE | |
| **Inpatient Hospital Care**[1,2] | The copays for hospital skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.<br><br>Our plan covers an **unlimited** number of days for an inpatient hospital stay.<br><br>• **$365 copay** per day for days 1 through 5<br>• **You pay nothing** per day for days 6 through 90<br>• **You pay nothing** per day for days 91 and beyond |
| **Inpatient Mental Health Care** | For inpatient mental health care, see the "Mental Health Care" section of this booklet. |
| **Skilled Nursing Facility (SNF)**[1,2] | Our plan **covers up to 100 days** in a SNF.<br><br>• **You pay nothing** per day for days 1 through 20<br>• **$150 copay** per day for days 21 through 100 |

<table>
<tr><th></th><th>Generations Healthcare Classic (HMO)</th></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>How much do I pay?</td><td>For Part B drugs such as chemotherapy drugs[1]:<br>20% of the cost<br><br>Other Part B drugs[1]: 0-20% of the cost depending on the drug</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br><br>You may get your drugs at network retail pharmacies and mail order pharmacies.<br><br>Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-Month Supply</th><th>Three-Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$10 copay</td><td>$17.50 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$17 copay</td><td>$35 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$110 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 copay</td><td>$242.50 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>29% of the cost</td><td>Not Offered</td></tr>
</table>
Preferred Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-Month Supply</th><th>Three-Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$5 copay</td><td>$12.50 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$12 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 copay</td><td>$105 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$95 copay</td><td>$237.50 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>29% of the cost</td><td>Not Offered</td></tr>
</table></td></tr>
</table>

<table>
<tr><th></th><th>Generations Healthcare Classic (HMO)</th></tr>
<tr><td>Initial Coverage<br>continued</td><td>
Standard Mail Order Cost-Sharing
<table>
<tr><th>Tier</th><th>One-Month Supply</th><th>Three-Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$5 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$12 copay</td><td>$17 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 copay</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$95 copay</td><td>$100 copay</td></tr>
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<tr><td>Tier 3 (Preferred Brand)</td><td>$42 copay</td><td>$42 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$95 copay</td><td>$95 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>29% of the cost</td><td>Not Offered</td></tr>
</table>
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br><br>
You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
</td></tr>
<tr><td>Coverage Gap</td><td>
Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.<br><br>
After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.
</td></tr>
<tr><td>Catastrophic Coverage</td><td>
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:<br>
• 5% of the cost, or<br>
• $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copay for all other drugs.
</td></tr>
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