GlobalHealth

2017 Summary of Benefits

January 1 – December 31, 2017

Generations Value (HMO)

Generations Classic (HMO)

Generations Select (HMO)

Generations Premier (HMO)

GlobalHealth is an HMO plan with a Medicare contract. Enrollment in GlobalHealth depends on contract renewal. You must continue to pay your Medicare Part B premium. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/ co-insurance may change on January 1 of each year.

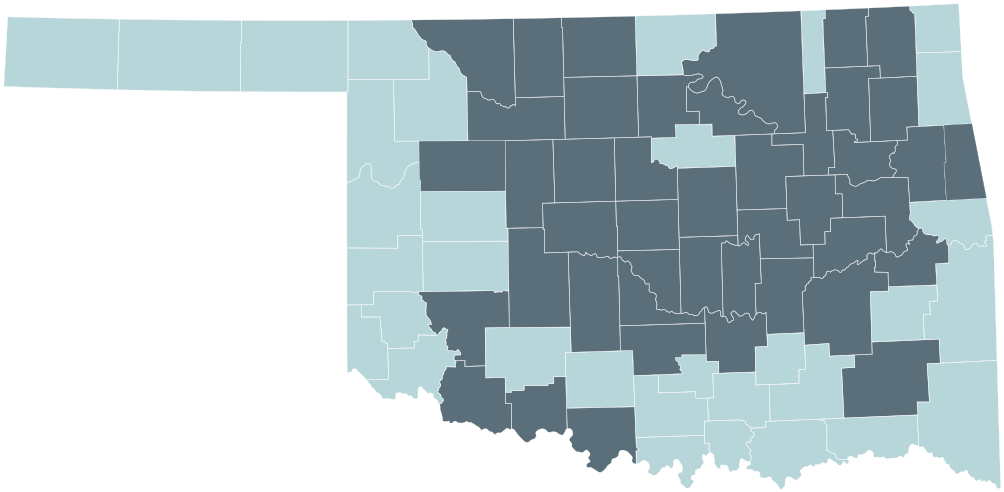
1-844-280-5555 (TTY users call 711)
8 a.m. to 8 p.m., 7 days a week
(October 1 - February 14)
8 a.m. to 8 p.m., Monday - Friday
(February 15 - September 30)
www.GlobalHealth.com/medicare

H3706_SB_PY2017 Accepted

This is a summary of drug and health plan services covered by GlobalHealth January 1, 2017 – December 31, 2017.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

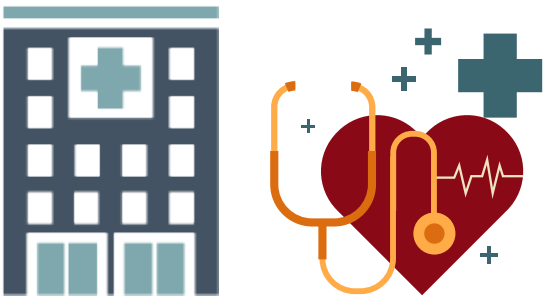
To join GlobalHealth, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Oklahoma:



Adair	Garfield	Major	Pawnee
Alfalfa	Garvin	Mayes	Pittsburg
Blaine	Grady	McClain	Pontotoc
Caddo	Grant	McIntosh	Pottawatomie
Canadian	Haskell	Muskogee	Pushmataha
Cherokee	Hughes	Noble	Rogers
Cleveland	Jefferson	Nowata	Seminole
Cotton	Kingfisher	Okfuskee	Tillman
Craig	Kiowa	Oklahoma	Tulsa
Creek	Lincoln	Okmulgee	Wagoner
Dewey	Logan	Osage	Woods

GlobalHealth 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.

2017
Medicare Advantage (MA-Only) Plan
(No Medicare Part D)



January 1, 2017 – December 31, 2017

Generations Value (MA) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,000 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $250 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $25 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $25 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay 20% of the cost • You pay $20 copay per visit • You pay $20 copay per visit • You pay 20% of the cost • You pay 20% of the cost	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for lab services, diagnostic tests and procedures, therapeutic radiology or outpatient x-rays is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $25 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay nothing • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam (1 per year)** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay nothing • You pay nothing • You pay 20% of the cost	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $250 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $10 copay per visit • You pay $10 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $105 for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $25 copay per visit • You pay $25 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $100 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) [1,2] • **Foot exams and treatment** • **Routine foot care**	• You pay $25 copay per visit • You pay $25 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies [1,2] • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics and related supplies (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices & medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing for preferred brand monitoring supplies • You pay 20% of the cost for non-preferred brand monitoring supplies	See the drug formulary for preferred/non-preferred status of monitoring supplies.
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Our plan does not cover Part D prescription drugs. Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

2017
Medicare Advantage Prescription Drug (MA-PD) Plans

January 1, 2017 – December 31, 2017

Generations Classic (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,300 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $365 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $40 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $30 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay $10 copay per visit • You pay $10 copay per visit • You pay $40 copay per visit • You pay $10 copay per visit	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for lab services, diagnostic tests and procedures, therapeutic radiology or outpatient x-rays is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $40 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay $5 copay per exam • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay $20 copay per visit • You pay 20% of the cost • You pay 20% of the cost	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $205 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit** [1,2] • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $279 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $20 copay per visit • You pay $20 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $150 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $40 copay per visit • You pay $40 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $100 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) [1,2] • **Foot exams and treatment** • **Routine foot care**	• You pay $40 copay per visit • You pay $40 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies [1,2] • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics and related supplies (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing for preferred brand monitoring supplies • You pay 20% of the cost for non-preferred brand monitoring supplies	See the drug formulary for preferred/non-preferred status of monitoring supplies.
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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.

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

January 1, 2017 – December 31, 2017

Generations Select (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $30	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $300 copay per day for days 1 through 8 • You pay nothing per day for days 9-90	
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $45 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Emergency Care	You pay $75 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $45 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay nothing • You pay nothing • You pay 20% of the cost • You pay nothing	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for therapeutic radiology is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $50 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay $5 copay per visit • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay $45 copay per visit • You pay $45 copay per visit • You pay $45 copay per pair • You pay nothing	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $300 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay $20 copay per visit • You pay $20 copay per visit	
Skilled Nursing Facility [1,2]	• You pay $10 copay per day for days 1 through 20 • $160 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $40 copay per visit • You pay $40 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	

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2 = Referral Required

Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $40 copay per visit • You pay $40 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.
PREMIUMS AND BENEFITS	**GENERATIONS SELECT**	**WHAT YOU SHOULD KNOW**
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing	
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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

January 1, 2017 – December 31, 2017

Generations Premier (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $111.30	You must continue to pay your Medicare Part B premium.
Deductible	You pay nothing	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$4,500 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
Inpatient Hospital Coverage[1,2]	• You pay $275 copay per day for days 1 through 3 • You pay nothing per day for days 4-190	Our plan covers 100 additional days for an inpatient hospital stay per benefit period.
Doctor Visits • **Primary** • **Specialists[1,2]**	• You pay nothing • You pay $30 copay per visit	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for all Original Medicare preventive services that are offered at $0 cost-sharing.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at $0 cost. Some services require referral and prior authorization. Some restrictions may apply.

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Emergency Care	You pay $50 copay per visit	If you are admitted to the hospital within 24 hours or outpatient surgical services are needed within 24 hours, you do not have to pay your copay for emergency care.
Urgently Needed Services	You pay $35 copay per visit	
Diagnostic Services/Labs/ Imaging • **Diagnostic radiology service (e.g., MRI)[1,2]** • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology[1,2]** • **Outpatient x-rays**	• You pay $150 copay per visit • You pay nothing • You pay nothing • You pay $30 copay per visit • You pay nothing	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information. Your share of the cost for therapeutic radiology is waived if during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam [1,2]** • **Supplemental exam (1 per year)**	• You pay nothing • You pay $25 copay per visit • You pay $20 copay per visit	
Dental Services • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Medicare-covered exams [1,2]**	• You pay nothing • You pay nothing • You pay nothing • You pay based on setting	Your cost-share for Medicare-covered exams is the same as for physician services at a doctor office, hospital outpatient surgery facility, ambulatory surgical center, emergency room or inpatient facility.
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses)** • **Eyeglasses or contact lenses after cataract surgery**	• You pay $45 copay per visit • You pay $45 copay per visit • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Supplemental eyeglasses limited to 1 pair per year. Our plan pays up to a total of $200 for all eye wear per year.

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient group therapy visit** • **Outpatient individual therapy visit**	• You pay $325 copay per day for days 1 through 3 • You pay nothing per day for days 4 through 190 • You pay nothing • You pay nothing	
Skilled Nursing Facility [1,2]	• You pay nothing per day for days 1 through 20 • You pay $50 copay per days for days 21 through 100	Our plan covers up to 100 days in a SNF. Prior hospital stay is not required.
Rehabilitation Services [1,2] • **Occupational therapy visit** • **Physical therapy and speech and language therapy visit**	• You pay $25 copay per visit • You pay $25 copay per visit	Prior authorization is required at least 2 business days prior to services being rendered. If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $50 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• $30 copay • $30 copay	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

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PREMIUMS AND BENEFITS	GENERATIONS PREMIER	WHAT YOU SHOULD KNOW
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen)** • **Prosthetics (e.g., braces, artificial limbs)** • **Diabetes supplies**	• You pay 20% of the cost • You pay nothing for surgically implanted devices and medical supplies • You pay 20% of the cost for external devices and medical supplies • You pay nothing	
Wellness Programs (e.g., fitness)	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost for chemotherapy drugs • You pay 0-20% of the cost for other part B drugs	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have 0% cost-sharing. All other Medicare Part B drugs will have 20% cost-sharing.

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PREMIUMS AND BENEFITS	GENERATIONS PREMIER			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply**	
Phase 2: Initial Coverage (You don't have a deductible)				
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	Cost-sharing may change depending on the pharmacy you choose and when you enter another phase for the Part D benefit. For more information on The additional pharmacies specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.
Tier 2: Generic	You pay $15 copay per fill	You pay $20 copay per fill	You pay $15 copay per fill	
Tier 3: Preferred Brand	You pay $42 copay per fill	You pay $47 copay per fill	You pay $84 copay per fill	
Tier 4: Non-Preferred Drug	You pay 40% of the cost per fill	You pay 50% of the cost per fill	You pay 30% of the cost per fill	
Tier 5: Specialty Tier	You pay 33% of the cost per fill	You pay 33% of the cost per fill	N/A	

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

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

8 a.m. to 8 p.m., 7 days a week (October 1 - February 14)
8 a.m. to 8 p.m., Monday - Friday (February 15 - September 30)
www.GlobalHealth.com/medicare

Provider & Pharmacy Directory:
www.GlobalHealth.com/search

Some of our plans 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 at www.GlobalHealth.com/medicare.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.