GlobalHealth

2018 Summary of Benefits

January 1 – December 31, 2018

Generations Value (HMO)

Generations Classic (HMO)

Generations Select (HMO)

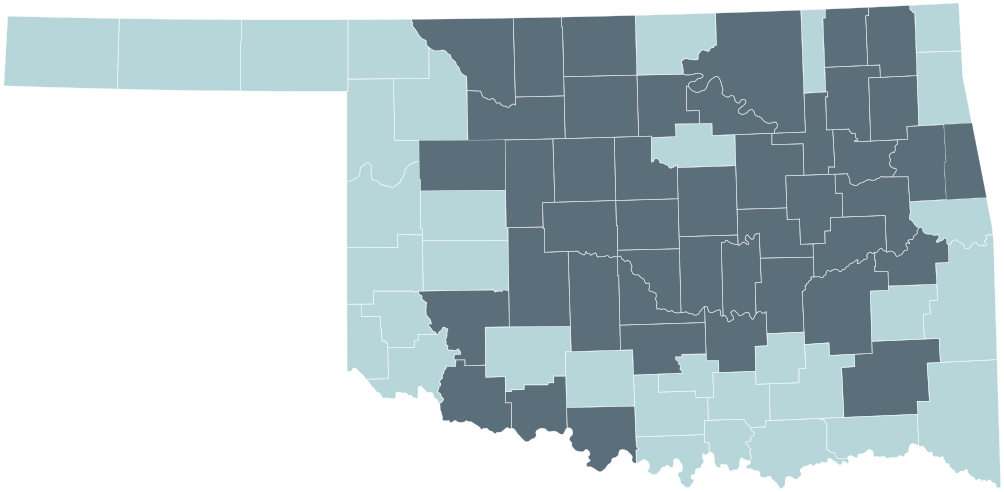
1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.
7 days a week (October 1 - February 14)
Monday - Friday (February 15 - September 30)
www.GlobalHealth.com/medicare

H3706_SB_PY2018 Accepted

This is a summary of drug and health plan services covered by GlobalHealth January 1, 2018 - December 31, 2018.

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 see the "Evidence of Coverage." You can request a copy from customer care at 844-280-5555 (TTY: 711), or it can be found online at https://GlobalHealth.com/medicare-advantage/member-materials.

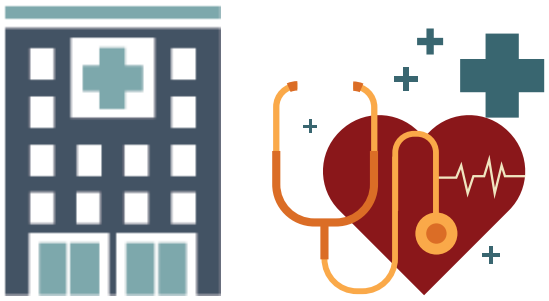
To join GlobalHealth, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Oklahoma:



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.

2018
Medicare Advantage (MA-Only) Plan
(No Medicare Part D)



January 1, 2018 – December 31, 2018

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 (Days 1-5) • You pay nothing per day (Days 6-190)	
Outpatient Hospital Services [1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $300 copay per visit • You pay $320 copay per visit	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.
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.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Preventive Care	You pay nothing for Medicare-covered preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered.
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 $10 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 $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $50 copay per visit • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received 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 nothing • You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
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 $50 copay • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts, limited to 1 per year. Our plan pays up to a total of $200 for all supplemental eyewear per year.
Mental Health Services • **Inpatient visit** [1,2] • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $275 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay $25 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day (Days 1-20); You pay $160 copay per day (Days 21-100)	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 $20 copay per visit • You pay $20 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.

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Transportation	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost	This plan does not cover Part D prescription drugs.
Home Health Services [1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen) [1]** • **Prosthetics and related supplies (e.g., braces, artificial limbs)[1]** • **Diabetes supplies [1,2]**	• 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	
Chiropractic Services	You pay $20 copay	
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.

2018
Medicare Advantage Prescription Drug (MA-PD) Plans

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)	You pay $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 $365 copay per day (Days 1-5) • You pay nothing per day (Days 6-190)	
Outpatient Hospital Services [1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $300 • You pay $320 copay	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.
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.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Preventive Care	You pay nothing for Medicare-covered preventive services	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $100 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 $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $50 copay per visit • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received 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]** • **Dentures**	• You pay nothing • You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.) • You pay nothing	Prosthodontics only covers dentures up to a maximum benefit of $750 per year.

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
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 nothing • You pay $40 copay • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts, limited to 1 per year. Our plan pays up to a total of $200 for all supplemental eyewear per year.
Mental Health Services • **Inpatient visit** [1,2] • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $275 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay $25 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day (Days 1-20); You pay $160 copay per day (Days 21-100)	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 $20 copay per visit • You pay $20 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.

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PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Transportation	Not covered	
Medicare Part B Drugs [1,2]	• You pay 20% of the cost	
Home Health Services [1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen) [1]** • **Prosthetics and related supplies (e.g., braces, artificial limbs) [1]** • **Diabetes supplies [1,2]**	• 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	
Chiropractic Services	You pay $20 copay	
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.

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PREMIUMS AND BENEFITS	GENERATIONS CLASSIC			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
Phase 2: Initial Coverage (You don't have a deductible)	**Preferred Retail Rx 30-day supply**	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay $10 copay per fill	Cost-sharing may differ depending on the pharmacy's status (e.g. preferred, non-preferred, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g. 30 or 90 days supply). 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 $30 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	
Phase 3: Coverage Gap Stage After your prescription costs reach $3,750		Your costs will be no more than 44% of the cost for generic drugs. You pay 35% of the cost of brand name drugs.		
Gap Coverage		You pay the same cost sharing for Tier 1 drugs that you paid in the Initial Coverage Stage or 44% of thecost, whichever is less, and the plan pays the rest.		
Phase 4: Catastrophic Coverage Stage After you have paid $5,000 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.35 for generics/$8.35 for brand names.		

PLEASE NOTE: Generations Classic and Generations Select have different drug formularies. Please visit our website for the most up-to-date drug formularies. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

*Costs for 90-day supply are higher at Standard Retail Pharmacy

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 $29	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 $325 copay per day (Days 1-5) • You pay nothing per day (Days 6-90)	
Outpatient Hospital Services [1,2] • **Chemotherapy administration** • **Observation services** • **Surgery**	• You pay 20% of the cost per visit • You pay $150 • You pay $320 copay	If you are admitted to the hospital as an inpatient after outpatient surgery or outpatient observation, the outpatient cost-share is waived and the inpatient cost-share applies.
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.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Preventive Care	You pay nothing for all Medicare-covered preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $85 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 $100 copay per visit • You pay nothing • You pay $100 for sleep studies in an outpatient facility; all other diagnostic tests and procedures, you pay nothing • You pay $40 copay • You pay nothing	Prior authorization is required for some services. Your share of the cost for therapeutic radiology is waived if received during an office visit.
Hearing Services • **PCP diagnostic evaluation** • **Specialist exam[1,2]**	• You pay nothing • You pay $25 copay per visit	
Preventive 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 (doctor's office, emergency room, etc.)	

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Comprehensive Dental Services • **Non-routine services** • **Diagnostic services** • **Restorative Services** • **Endodontics** • **Periodontics** • **Extractions**	• You pay nothing	Our plan pays up to a total of $250 for comprehensive dental services per year.
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 nothing • You pay $35 copay • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts, limited to 1 per year. Our plan pays up to a total of $200 for all supplemental eyewear per year.
Mental Health Services • **Inpatient visit [1,2]** • **Outpatient mental health visit** • **Outpatient psychiatric visit**	• You pay $250 copay per day (Days 1-6); You pay nothing per day (Days 7-90) • You pay nothing • You pay $25 copay per visit	
Skilled Nursing Facility [1,2]	• You pay nothing per day (Days 1-20); You pay $160 copay per day (Days 21-100)	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 $10 copay per visit • You pay $10 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.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
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	
Medicare Part B Drugs [1,2]	• You pay 20%	
Home Health Services [1,2]	You pay nothing	You pay regular cost-sharing for services or equipment not provided through a home health agency.
Medical Equipment/Supplies • **Durable Medical Equipment (e.g., wheelchairs, oxygen) [1]** • **Prosthetics (e.g., braces, artificial limbs) [1]** • **Diabetes supplies [1,2]**	• 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	
Chiropractic Services	You pay $20 copay	
Foot Care (podiatry services) • **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.

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PREMIUMS AND BENEFITS	GENERATIONS SELECT			WHAT YOU SHOULD KNOW
OUTPATIENT PRESCRIPTION DRUGS				
Phase 2: Initial Coverage (You don't have a deductible)	**Preferred Retail Rx 30-day supply**	**Standard Retail Rx 30-day supply**	**Preferred Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay $10 copay per fill	Cost-sharing may differ depending on the pharmacy's status (e.g. preferred, non-preferred, mail-order, Long Term Care (LTC), or home infusion) or the supply (e.g. 30 or 90 days supply). 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 $30 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	
Phase 3: Coverage Gap Stage After your prescription costs reach $3,750		Your costs will be no more than 44% of the cost for generic drugs. You pay 35% of the cost of brand name drugs.		
Gap Coverage		You pay the same cost sharing for Tier 1 drugs that you paid in the Initial Coverage Stage or 44% of thecost, whichever is less, and the plan pays the rest.		
Phase 4: Catastrophic Coverage Stage After you have paid $5,000 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.35 for generics/$8.35 for brand names.		

PLEASE NOTE: Generations Classic and Generations Select have different drug formularies. Please visit our website for the most up-to-date drug formularies. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

*Costs for 90-day supply are higher at Standard Retail Pharmacy

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.

Customer Care: 1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.
7 days a week (October 1 - February 14)
Monday - Friday (February 15 - September 30)

www.GlobalHealth.com/medicare-advantage

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

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.

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 copayments/coinsurance may change on January 1 of each year.

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 — 1-877-280-5852.

GlobalHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-280-5555 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-280-5555 (TTY: 711).