GlobalHealth

Annual Notice of Changes

January 1 – December 31, 2018

Generations Classic (HMO)

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

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_CLASSICEOC_V2_2018 File & Use 09/07/2017 Accepted

Generations Classic (HMO) offered by GlobalHealth, Inc.

Annual Notice of Changes for 2018

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

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

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

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.

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

- Are your doctors in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider & Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?

- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE: Decide whether** you want to change your plan

- If you want to **keep** Generations Classic (HMO), you don't need to do anything. You will stay in Generations Classic (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Generations Classic (HMO).
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Customer Care number at (405) 280-5555 (local) or 1-844-280-5555 (toll-free) for additional information. (TTY users should call 711.) Hours are 8:00 am to 8:00 pm, seven days a week, from October 1 – February 14, and 8:00 am to 8:00 pm Monday – Friday from February 15 – September 30.
- Customer Care has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is also available in large print.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Generations Classic (HMO)

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

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Generations Classic (HMO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,300	$3,400
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $40 per visit	Primary care visits: $0 per visit Specialist visits: $40 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	You pay a $365 copay per day for days 1 through 5. There is no coinsurance, copayment, or deductible for days 6 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.	You pay a $365 copay per day for days 1 through 5. There is no coinsurance, copayment, or deductible for days 6 through 90. There is no coinsurance, copayment, or deductible for days 91 through 190.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: Standard 30-day Retail

Cost	2017 (this year)	2018 (next year)
	Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 30% of the total cost • Drug Tier 5: 33% of the total cost.	Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Retail Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 40% of the total cost • Drug Tier 5: 33% of the total cost. Standard 30-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $20 • Drug Tier 3: $47 • Drug Tier 4: 50% of the total cost • Drug Tier 5: 33% of the total cost. Preferred 30-day Mail-order Cost-Share: • Drug Tier 1: $5 • Drug Tier 2: $15 • Drug Tier 3: $42 • Drug Tier 4: 30% of the total cost • Drug Tier 5: 33% of the total cost.

Cost	2017 (this year)	2018 (next year)
	Standard 90-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost	Standard 90-day Retail Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost
	Preferred 90-day Retail Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $126 • Drug Tier 4: 40% of the total cost	Preferred 90-day Retail Cost-Share: • Drug Tier 1: $15 • Drug Tier 2: $45 • Drug Tier 3: $126 • Drug Tier 4: 40% of the total cost
	Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $94 • Drug Tier 4: 50% of the total cost	Standard 90-day Mail-order Cost-Share: • Drug Tier 1: $30 • Drug Tier 2: $60 • Drug Tier 3: $141 • Drug Tier 4: 50% of the total cost
	Preferred 90-day Mail-order Cost-Share: • Drug Tier 1: $0 • Drug Tier 2: $15 • Drug Tier 3: $84 • Drug Tier 4: 30% of the total cost	Preferred 90-day Mail-order Cost-Share: • Drug Tier 1: $10 • Drug Tier 2: $30 • Drug Tier 3: $84 • Drug Tier 4: 30% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,300	$3,400 Once you have paid **$3,400** out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.GlobalHealth.com/medicare. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2018 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

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

Section 1.4 – Changes to the Pharmacy Network

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

There are changes to our network of pharmacies for next year. An updated *Provider & Pharmacy Directory* is located on our website at www.GlobalHealth.com/medicare. You may also call Customer Care for updated provider information or to ask us to mail you a *Provider & Pharmacy Directory*. **Please review the 2018 *Provider & Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*.

Cost	2017 (this year)	2018 (next year)
Cardiac rehabilitation services	You pay a $40 copay per visit for Medicare-covered cardiac rehabilitation services. You pay a $40 copay per visit for Medicare-covered intensive cardiac rehabilitation services. Prior authorization is required.	You pay a $10 copay per visit for Medicare-covered cardiac rehabilitation or intensive cardiac rehabilitation services. Prior authorization is required.
Dental services	You pay a $40 copay per visit for Medicare-covered dental services. Prior authorization is required for Medicare-covered dental services.	You pay a $40 copay per office visit for Medicare-covered dental services. Services at other locations during Medicare-covered stays are included in the cost-sharing for those services Prior authorization is required.
	There is no coinsurance, copayment, or deductible for cleanings and dental x-rays. You pay a $5 copay per visit for oral exams.	There is no coinsurance, copayment or deductible for preventive dental services.
	Prosthodontics (dentures) are <u>not</u> covered.	There is no coinsurance, copayment, or deductible for dentures. We will only pay up to a total of $750 for dentures per year. If the dentures you purchase cost more than this allowed amount, you pay the amount that exceeds this allowance.
Diabetes self-management training, diabetic services and supplies	There is no coinsurance, copayment, or deductible for preferred brand Medicare-covered diabetes monitoring supplies. You pay 20% of the total cost for	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes monitoring supplies. Prior authorization is required for

Cost	2017 (this year)	2018 (next year)
	non-preferred brand Medicare-covered diabetes monitoring supplies. The Drug List will indicate preferred status. Prior authorization is required.	some items. The Drug List will indicate which ones.
	You pay 20% of the total cost for Medicare-covered therapeutic shoes or inserts. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered therapeutic shoes or inserts. Prior authorization is required.
	There is no coinsurance, copayment, or deductible for diabetes self-management training. If other medical services are provided, for other medical conditions, in the same visit, then the appropriate physician cost-sharing applies for the additional services rendered during that office visit. Prior authorization is required.	There is no coinsurance, copayment, or deductible for diabetes self-management training. Prior authorization is not required.
Emergency care	You pay a $75 copay per visit for all Medicare-covered emergency care services received during the visit. If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay the emergency care copay. If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copay. If you receive emergency care at an out-of-network hospital and need inpatient care after your	You pay a $100 copay per visit for all Medicare-covered emergency care services received during the visit. If you are admitted to the hospital as inpatient or to outpatient observation within 24 hours for the same condition, you do not have to pay the emergency care copay. If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copay. If you receive emergency care at an out-of-network hospital and

Cost	2017 (this year)	2018 (next year)
	emergency condition is stabilized, we will try to arrange for network providers to take over care as soon as the medical condition and the circumstances allow. Otherwise, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.	need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Inpatient mental health care	For Medicare-covered hospital stays in a network hospital: • You pay a $279 copay per day for days 1 through 6. • There is no coinsurance, copayment, or deductible for days 7 through 90. Hospital copays apply on the date of admission. Prior authorization is required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.	For each Medicare-covered hospital stay in a network hospital: • You pay a $275 copay per day for days 1 through 6. • There is no coinsurance, copayment, or deductible for days 7 through 90. Hospital copays apply on the date of admission. Prior authorization is required. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.
Medicare Diabetes Prevention Program (MDPP)	Not covered.	There is no coinsurance, copayment, or deductible for the MDPP benefit. Prior authorization is required.
Medicare Part B prescription drugs	You pay 20% of the total cost for Medicare Part B covered drugs.	You pay 20% of the total cost for Medicare Part B covered drugs.

Cost	2017 (this year)	2018 (next year)
	Respiratory compound medications administered via a nebulizer provided by Pacific Coast Pharmacy will have a 0% cost-sharing. All other Medicare Part B drugs will have a 20% cost-sharing. Prior authorization is required.	Prior authorization is required.
Outpatient diagnostic tests and therapeutic services and supplies	You pay a $10 copay per visit for Medicare-covered services for: • Lab services • Diagnostic procedures and tests • Outpatient X-rays There is no coinsurance, copayment, or deductible for Medicare-covered surgical supplies, devices used to reduce fractures and dislocations, or blood. If these services are performed during a physician's office visit you do not have to pay the outpatient diagnostic tests and therapeutic services and supplies copay.	There is no coinsurance, copayment, or deductible for Medicare-covered x-rays, laboratory tests, outpatient diagnostic tests (such as, ultrasounds, electrocardiograms, electroencephalograms). There is no coinsurance, copayment, or deductible for Medicare-covered sleep studies in your home. You pay a $100 copay per visit for Medicare-covered sleep studies in an outpatient facility setting. Prior authorization is required. There is no coinsurance, copayment, or deductible for Medicare-covered surgical supplies, devices used to reduce fractures and dislocations, or blood.
	You pay a $40 copay per visit for therapeutic radiology services. If these services are performed during a physician's office visit you do not have to pay the outpatient diagnostic tests and therapeutic services and supplies	You pay a $50 copay per visit for Medicare-covered therapeutic radiology services. If these services are performed during a physician's office visit you do not have to pay the therapeutic radiology copay.

Cost	2017 (this year)	2018 (next year)
	copay. Prior authorization is required. You pay a $150 copay per visit for Medicare-covered diagnostic radiology services (such as MRIs, CT scans). Prior authorization is required for therapeutic radiology services and diagnostic radiology services (except for emergency care).	Prior authorization is required. You pay a $150 copay per visit for other Medicare-covered outpatient diagnostic tests, including but not limited to MRI, CT, PET, and diagnostic colonoscopy. Prior authorization is required.
Outpatient hospital services	You pay a $250 copay per visit for Medicare-covered services in a preferred outpatient facility. You pay a $320 copay per visit for Medicare-covered services in a non-preferred outpatient facility. The *Provider & Pharmacy Directory* will indicate preferred status. If you are admitted to the inpatient acute level of care from outpatient services, you do not have to pay the outpatient hospital services copay. See "Partial hospitalization services" for cost-sharing information. Prior authorization is required (except for emergency care).	You pay a $100 copay per visit for all Medicare-covered emergency care services received during the visit. If you are admitted to the hospital as inpatient or to outpatient observation within 24 hours for the same condition, you do not have to pay the emergency care copay. If you have outpatient surgical services within 24 hours for the same condition, you do not have to pay the emergency care copay. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital. You pay a copay of $300 per visit for Medicare-covered observation services. If you are admitted to the inpatient

Cost	2017 (this year)	2018 (next year)
		acute level of care from observation, you do not have to pay the outpatient hospital services copay. You pay a $320 copay per visit for Medicare-covered outpatient surgery services. If you are admitted to the inpatient acute level of care from outpatient services, you do not have to pay the outpatient hospital services copay. Prior authorization is required. There is no coinsurance, copayment, or deductible for Medicare-covered laboratory, x-rays, medical supplies, and certain screenings and preventive services. You pay 20% of the total cost for the drug and the administration of drugs and biologicals that you can't give yourself. Prior authorization is required. You pay a $40 copay per day for Medicare-covered partial hospitalization program services. Prior authorization is required.
Outpatient mental health care	You pay a $20 copay per visit for Medicare-covered individual therapy sessions. You pay a $20 copay per visit for Medicare-covered group therapy sessions.	Individual and/or group therapy sessions provided by a state-licensed psychiatrist or doctor. Medication management and therapy services provided by a state-licensed psychiatrist. You pay a $25 copay per

Cost	2017 (this year)	2018 (next year)
		Medicare-covered session. Individual and/or group therapy sessions provided by a state-licensed clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. There is no coinsurance, copayment, or deductible for Medicare-covered sessions.
Outpatient rehabilitation services	You pay a $40 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy. Prior authorization required at least two (2) business days prior to services being rendered. If these services are provided at your home, you pay the home health cost-sharing instead. Prior authorization required at least two (2) business days prior to services being rendered.	You pay a $20 copay per visit for Medicare-covered occupational therapy, physical therapy, and/or speech and language therapy in an outpatient setting. Prior authorization required at least two (2) business days prior to services being rendered. There is no coinsurance, copayment, or deductible for Medicare-covered services in your home. Prior authorization required at least two (2) business days prior to services being rendered.
Outpatient substance abuse services	You pay a $20 copay per visit for Medicare-covered individual therapy sessions. You pay a $20 copay per visit for Medicare-covered group therapy sessions.	Individual and/or group therapy sessions provided by a state-licensed psychiatrist or doctor. Medication management and therapy services provided by a state-licensed psychiatrist. You pay a $25 copay per Medicare-covered session.

Cost	2017 (this year)	2018 (next year)
		Individual and/or group therapy sessions provided by a state-licensed clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. There is no coinsurance, copayment, or deductible for Medicare-covered sessions.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a $250 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $250 copay per visit for Medicare-covered services in a preferred outpatient facility. You pay a $320 copay per visit for Medicare-covered services in a non-preferred outpatient facility. The *Provider & Pharmacy Directory* will indicate preferred status. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery, you do not have to pay the outpatient surgery or ambulatory surgery copay. Prior authorization is required.	You pay a $250 copay per visit for Medicare-covered services in an ambulatory surgical center. You pay a $320 copay per visit for Medicare-covered services in an outpatient surgery department. If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery, you do not have to pay the outpatient surgery or ambulatory surgery copay. Prior authorization is required.
Over-the-counter items	Not covered.	You are eligible for a $50 quarterly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order service. One order in

Cost	2017 (this year)	2018 (next year)
		each three month-period. The unused balance does not carry over to the next three months. Prices include shipping, handling, and sales tax. Items may be purchased for the member only. You pay the prices listed in the catalog. See our website, www.GlobalHealth.com/medicare for the catalog and order form.
Services to treat kidney disease and conditions	There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services including self-dialysis training. Prior authorization is required.	There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services including self-dialysis training. Prior authorization is required.
	You pay 20% of the total cost for Medicare-covered renal dialysis.	You pay a $30 copay for each Medicare-covered renal dialysis treatment in an outpatient facility. Prior authorization is required.
		No additional charge for dialysis in during a Medicare-covered inpatient hospital admission. Refer to “Inpatient hospital care” in the Medical Benefits Chart of the Evidence of Coverage for cost share. Prior authorization is required.
	You pay the home health agency care cost share for home dialysis equipment if provided by a home health agency. Otherwise, you pay the durable medical equipment cost share.	You pay the home health agency care cost share for home dialysis equipment if provided by a home health agency. Otherwise, you pay the durable medical equipment cost share.
	You pay the home health agency	There is no coinsurance, copayment, or deductible for

Cost	2017 (this year)	2018 (next year)
	care cost share for home support services. Prior authorization is required.	Medicare-covered self-dialysis or home support services. Certain drugs for dialysis are covered under Part B drug benefit. Prior authorization is required.
Skilled nursing facility (SNF) care	For Medicare-covered skilled nursing facility stays: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a $150 copay per day for days 21 through 100. Prior authorization is required.	For Medicare-covered skilled nursing facility stays per benefit period: • There is no coinsurance, copayment, or deductible for days 1 through 20. • You pay a $160 copay per day for days 21 through 100. Prior authorization is required.
Urgently needed services	You pay a $30 copay per visit for Medicare-covered urgently needed services.	You pay a $35 copay per visit for Medicare-covered urgently needed services.
Vision care	There is no coinsurance, copayment, or deductible for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including glaucoma screening. Prior authorization is required for glaucoma screening.	There is no coinsurance, copayment, or deductible for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. There is no coinsurance, copayment, or deductible for Medicare-covered screenings. Prior authorization is <u>not</u> required.
	You pay 20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.	There is no coinsurance, copayment, or deductible for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.
	You pay a $20 copay for one supplemental routine eye exam per	There is no coinsurance, copayment, or deductible for one

Cost	2017 (this year)	2018 (next year)
	year. You pay 20% of the total cost for one supplemental pair of eyeglasses (frames and lenses) per year. We will only pay up to a total of $205 for all eye wear per year. If the eye wear you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance.	supplemental exam. Choice of one supplemental pair of eyeglasses (frames and lenses) or one set of contact lenses per year. You pay a $40 copay. We will only pay up to a total of $200 for supplemental eye wear per year. If the eye wear you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance.
Wigs for Hair Loss Related to Chemotherapy	You pay 20% of the total cost for wigs for hair loss related to chemotherapy. We will only pay up to a total of $150 for wig(s) for hair loss related to chemotherapy per year. If the wig(s) you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. Prior authorization is required.	You pay a $15 copay for wigs for hair loss related to chemotherapy. We will only pay up to a total of $150 for wig(s) for hair loss related to chemotherapy per year. If the wig(s) you purchase costs more than this allowed amount, you pay the amount that exceeds this allowance. Prior authorization is required.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

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

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.

  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Care.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition.

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

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2017, please call Customer Care and ask for the "LIS Rider." Phone numbers for Customer Care are in Section 7.1 of this booklet.

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

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

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

Stage	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-preferred Drugs):** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** *Standard cost-sharing:* You pay $10 per prescription. *Preferred cost-sharing:* You pay $5 per prescription. **Tier 2 (Generic Drugs):** *Standard cost-sharing:* You pay $20 per prescription. *Preferred cost-sharing:* You pay $15 per prescription. **Tier 3 (Preferred Brand Drugs):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $42 per prescription. **Tier 4 (Non-preferred Drugs):** *Standard cost-sharing:* You pay 50% of the total cost. *Preferred cost-sharing:* You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 33% of the total cost.

Stage	2017 (this year)	2018 (next year)
	_____ Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage).	_____ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

SECTION 2 Administrative Changes

The items below have a change in prior authorization requirements or Part D prescription drug coverage.

Cost	2017 (this year)	2018 (next year)
Ambulance services	Prior authorization is not required.	Prior authorization is required for non-emergency transportation.
Colorectal cancer screening	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. Prior authorization is required.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. Prior authorization is required for FIT-DNA based tests, flexible sigmoidoscopy and screening colonoscopy.
Screening for lung cancer with low dose computed tomography (LDCT)	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making

Cost	2017 (this year)	2018 (next year)
	visit or for the LDCT. Prior authorization is not required.	visit or for the LDCT. Prior authorization is required.
Part D gap coverage	No additional coverage.	Additional coverage for Tier 1.
Part D drug tier exceptions	Tiers 2 and 4	Tier 4 only
Long term care pharmacy one month supply	34 days	31 days

SECTION 3 Deciding Which Plan to Choose

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

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, GlobalHealth, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Generations Classic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Generations Classic (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2018.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

Senior Health Insurance Counseling Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Senior Health Insurance Counseling Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Counseling Program (SHIP) at 1-800-763-2828. You can learn more about Senior Health Insurance Counseling Program (SHIP) by visiting their website (www.ship.oid.ok.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HIV Drug Assistance Program (HDAP) at (405) 271-4636.

SECTION 7 Questions?

Section 7.1 – Getting Help from Generations Classic (HMO)

Questions? We're here to help. Please call Customer Care at (405) 280-5555 (local) or 1-844-280-5555 (toll-free). (TTY only, call 711.) We are available for phone calls 8:00 am to 8:00 pm, seven days a week, from October 1 – February 14, and 8:00 am to 8:00 pm Monday – Friday from February 15 – September 30. Calls to these numbers are free.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Generations Classic (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at www.GlobalHealth.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

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

Read *Medicare & You 2018*

You can read the *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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)
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www.GlobalHealth.com/medicare