



GlobalHealth

2019 Summary of Benefits

January 1 –
December 31, 2019



Generations State of
Oklahoma Group Retirees
(HMO)

1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.

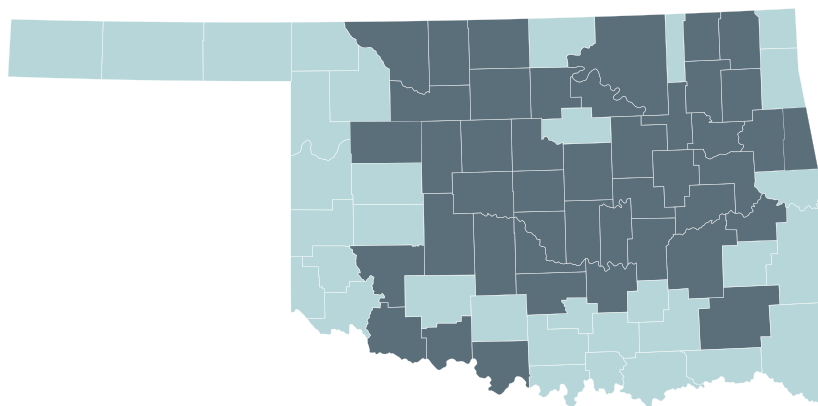
7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)
www.GlobalHealth.com/osr

H3706_OSRSB_PY2019_M

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

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

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

Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

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

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

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

2019 Medicare Advantage Prescription Drug (MA-PD) Plans



Generations State of Oklahoma Group Retirees (MA-PD) Summary of Benefits

PREMIUMS AND BENEFITS	GENERATIONS STATE OF OKLAHOMA GROUP RETIREES	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay \$192	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 \$250 copay	
Outpatient Hospital Services ^{1,2} <ul style="list-style-type: none"> • Observation services • Surgery 	<ul style="list-style-type: none"> • You pay \$150 • You pay \$200 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 <ul style="list-style-type: none"> • Primary • Specialists^{1,2} 	<ul style="list-style-type: none"> • You pay nothing • You pay \$20 copay per visit 	There is no prior authorization for routine OB/GYN care.
Preventive Care	You pay nothing for Medicare-covered preventive services.	Any additional preventive services approved by Medicare during the contract year will be covered.

1 = Prior Authorization Required

2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS STATE OF OKLAHOMA GROUP RETIREES	WHAT YOU SHOULD KNOW
Emergency Care	<ul style="list-style-type: none"> You pay \$75 copay per visit 	<p>If you are admitted to observation, 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.</p>
Urgently Needed Services	<ul style="list-style-type: none"> You pay \$20 copay per visit 	
Diagnostic Services/Labs/ Imaging <ul style="list-style-type: none"> Diagnostic radiology service (e.g., MRI)^{1,2} Lab services Diagnostic tests and procedures Therapeutic Radiology^{1,2} Outpatient x-rays 	<ul style="list-style-type: none"> 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 \$40 copay per visit You pay nothing 	<p>Prior authorization is required for some services. Please contact the plan for more information.</p>
Hearing Services <ul style="list-style-type: none"> PCP diagnostic evaluation Specialist exam^{1,2} 	<ul style="list-style-type: none"> You pay nothing You pay \$20 copay per visit 	
Dental Services <ul style="list-style-type: none"> Medicare-covered services^{1,2} 	<ul style="list-style-type: none"> You pay based on setting (doctor's office, emergency room, etc.) 	

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PREMIUMS AND BENEFITS	GENERATIONS STATE OF OKLAHOMA GROUP RETIREES	WHAT YOU SHOULD KNOW
Vision Services <ul style="list-style-type: none"> • Medicare-covered eye exam • Supplemental eye exam • Eyeglasses or contact lenses after cataract surgery • Supplemental eyeglasses or contact lenses 	<ul style="list-style-type: none"> • You pay nothing • You pay nothing • You pay nothing • You pay nothing 	<p>Supplemental eye exam limited to 1 per year.</p> <p>Choice of 1 supplemental eyeglasses or contacts, limited to 1 per year.</p> <p>Our plan pays up to \$200 for supplemental eye wear per year.</p>
Mental Health Services <ul style="list-style-type: none"> • Inpatient visit ^{1,2} • Outpatient mental health visit • Outpatient psychiatric visit 	<ul style="list-style-type: none"> • You pay nothing • You pay nothing • You pay \$20 copay per visit 	
Skilled Nursing Facility ^{1,2}	<ul style="list-style-type: none"> • You pay nothing per day for days 1 through 20 • You pay \$160 copay per day for days 21 through 100 	<p>Our plan covers up to 100 days in a SNF.</p> <p>Prior hospital stay is not required.</p>
Rehabilitation Services ^{1,2} <ul style="list-style-type: none"> • Occupational therapy visit • Physical therapy and speech and language therapy visit 	<ul style="list-style-type: none"> • You pay \$20 copay per visit • You pay \$20 copay per visit 	<p>Prior authorization is required. If these services are provided in your home, then the home health cost-sharing applies instead.</p>
Ambulance	<p>You pay \$50 copay per occurrence</p>	<p>One-way trip.</p> <p>If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.</p>
Transportation	<p>Not covered</p>	

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PREMIUMS AND BENEFITS	GENERATIONS STATE OF OKLAHOMA GROUP RETIREES	WHAT YOU SHOULD KNOW
Medicare Part B Drugs ^{1,2}	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Durable Medical Equipment (e.g., wheelchairs, oxygen) ¹ Prosthetics and related supplies (e.g., braces, artificial limbs) ¹ Diabetes supplies ^{1,2} 	<ul style="list-style-type: none"> 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 	
Chiropractic Services	You pay \$20 copay	

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PREMIUMS AND BENEFITS	GENERATIONS STATE OF OKLAHOMA GROUP RETIREES			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 \$15 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 \$45 copay per fill	
Tier 3: Preferred Brand**	You pay \$42 copay per fill	You pay \$47 copay per fill	You pay \$126 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 40% 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	
Tier 6: Select Care Drugs	You pay \$5 copay per fill	You pay \$10 copay per fill	You pay nothing	
Phase 3: Coverage Gap Stage After your prescription costs reach \$3,820	For generic drugs in Tiers 1 and 6, you pay either the same copayment as in the Initial Coverage Stage or 37% of the costs, whichever is lower. For brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee). For insulin in Tier 3, you pay either the same copayment as in the Initial Coverage Stage or 25% of the costs, whichever is lower.			You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$5,100. This amount and rules for counting costs toward this amount have been set by Medicare.
Phase 4: Catastrophic Coverage Stage After you have paid \$5,100 out-of-pocket	You pay the greater of 5% of the cost of the drug or \$3.40 for generics/\$8.50 for brand names.			

PLEASE NOTE: 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

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



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Monday - Friday (April 1 - September 30)

www.GlobalHealth.com/medicare

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/osr.

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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).