Generations Medicare Advantage Plans

GlobalHealth

2020 Medicare Advantage Agent Product Training

An Oklahoma-Based HMO

Disclaimer: For internal training purposes only. Not intended for viewing by public.

Plan Year 2020 Product Training Overview

- How Generations Medicare Advantage Plans Work
- Eligibility & Service Area
- 2020 Plan Options
- Supplemental Benefits
- Provider Network

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How Generations Medicare Advantage Plans Work

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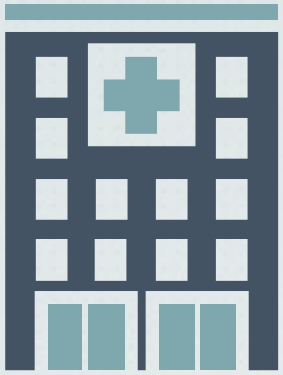
The Four Parts of Medicare




PART A

Hospital Insurance

PART B

Medical Insurance

PART C

Medicare Advantage Plan (HMO, PPO, PFFS) Includes Part A, Part B and Sometimes Part D Coverage

PART D

Medicare Prescription Drug Coverage

GlobalHealth offers MA-only (Part C) and MA-PD (Part C + Part D) plans.
GlobalHealth Medicare Advantage Plans replace Original Medicare.

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How do our MA and MA-PD Plans work?

Members must:

- Select a Primary Care Physician (PCP) at the time of enrollment
- Use in-network providers (specialists, hospitals, etc.)
- Obtain prior authorization prior to using certain services (*please see the Evidence of Coverage ("EOC") for a full list of benefits covered by GlobalHealth and prior authorization requirements*)
- Use only their GlobalHealth ID card (*as of their effective date, members will not use their red, white and blue Medicare card while on our plan*)
- FOR MA-PD: Use medications on GlobalHealth's formulary

GlobalHealth

How do our MA and MA-PD Plans work?

Agents must:

- Review the plan benefits for the plan the enrollee wishes to discuss (*you must obtain a scope of appointment that specifies what plan/plan type is being discussed with the prospective enrollee – this must be provided to GlobalHealth with the enrollment application)*
- Review prospective enrollees' providers to ensure they are in the GlobalHealth network (*use the online provider search tool located at https://www.globalhealth.com/provider-search/*)
- Explain the prior authorization requirements under a GlobalHealth Generations Medicare Advantage Plan (*please see the EOC for a full list of benefits covered by GlobalHealth and prior authorization requirements*)
- FOR MA-PD: Review prospective enrollees' medications to ensure they are available on GlobalHealth's formulary and clarify any coverage requirements/limitations

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Benefits of Having a Health Maintenance Organization (HMO)

- A Health Maintenance Organization (HMO) is a type of health insurance plan that provides health care to its members through networks of doctors and hospitals
- Members have a Primary Care Physician (PCP) who coordinates his/her care with other in-network providers/facilities – e.g., submitting referrals for certain services (such as therapy, tests, or surgery)
- A closed network of high-quality providers allows GlobalHealth to offer competitive benefits, including low copayments for benefits that can be used everyday (e.g., $0 primary care physician copay)

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Benefits of Having a Primary Care Physician (PCP)

- Overall health more closely managed
- Coordination with specialists and other providers
- Additional benefits
  - PCPs direct members to specialists they know and trust
  - PCPs are able to really know their patients and their history
  - PCP can proactively schedule covered Annual Wellness Visit and preventive services

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The Referral Process for Members

If…	When…	Then…
In Network	The doctor determines a member requires specialized treatment	The doctor will refer the member to a provider within the GlobalHealth network Referrals for services that require prior authorization will be sent to GlobalHealth for review
Out-of- Network	N/A	Generations Medicare Advantage plans have no out-of-network coverage except for: • Emergency Treatment • Urgently needed care

NOTE Please see the EOC for a full list of benefits covered by GlobalHealth and prior authorization requirements

GlobalHealth

The Authorization Process

If a doctor determines a member requires specialized treatment that requires prior authorization, the doctor will submit a referral on behalf of the member to GlobalHealth. Then, GlobalHealth will review for benefit coverage and medical necessity.

There are several services that *do not* require referral or prior authorization, such as:

- Emergency or urgent care
- Labs, x-rays, and other simple diagnostic tests
- Seeing a specialist (the specialist may need to submit a referral for authorization for subsequent services such as therapy, specialized diagnostic tests, or surgery)
- Outpatient mental health and substance use disorder office visits
- Preventive care

NOTE

Please see the EOC for a full list of benefits covered by GlobalHealth and prior authorization requirements

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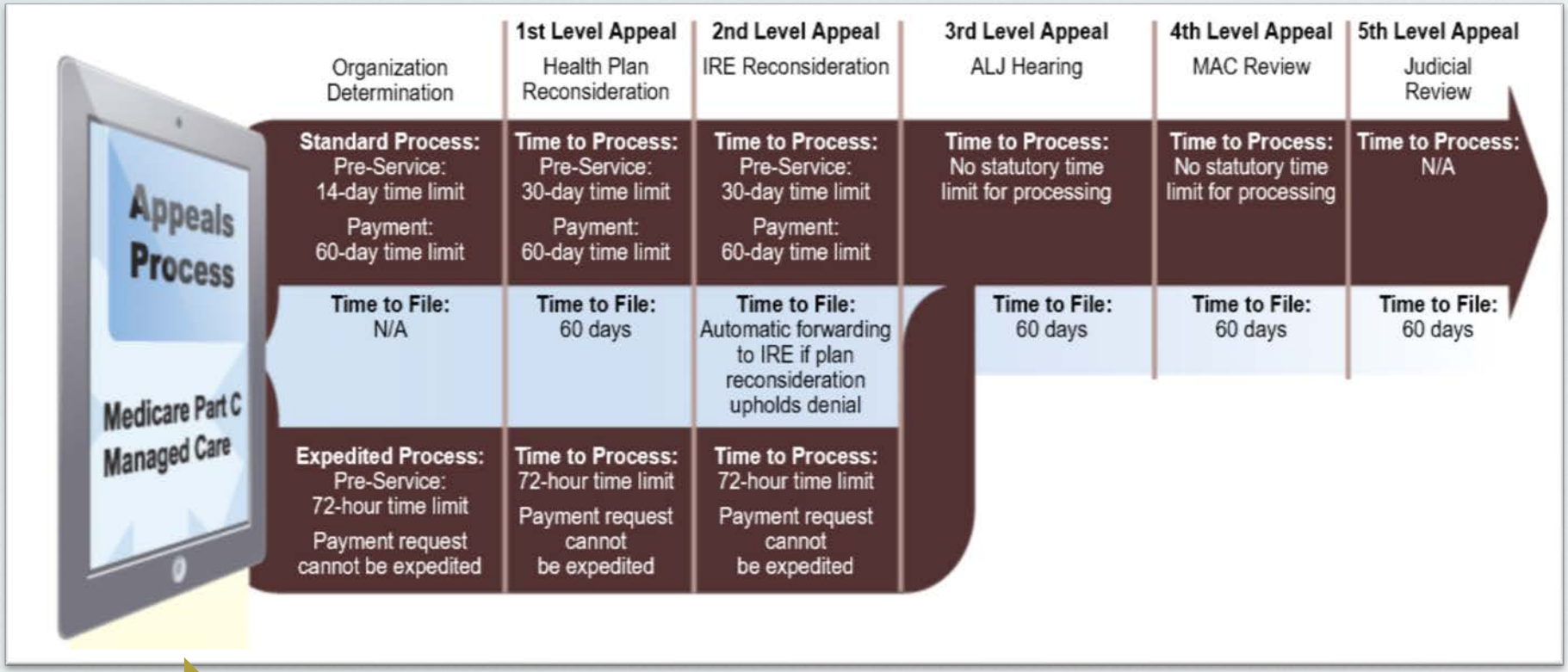
Part C Appeals & Grievances

Term	Definition
Appeal	An appeal is any of the procedures that deal with the review of an adverse organization determination (denial of coverage/payment) made by the plan on the benefits or on any amounts the enrollee must pay for the coverage.
Grievance	A grievance is any complaint or dispute expressing dissatisfaction with any aspect of operations, activities, or behavior of a Part C plan, regardless of whether remedial action is requested.
Independent Review Entity (IRE)	The IRE is an independent entity contracted to CMS to review Part C plan denials.
Organization Determination	An organization determination is any decision made by, or on behalf of, GlobalHealth regarding payment or benefits to which an enrollee believes he/she is entitled. Pre-service organization determinations are considered prior authorizations, where GlobalHealth is making a determination to approve or deny coverage for the requested service. Post-service organization determinations are claims, where GlobalHealth is making a determination to approve or deny claim payment.
Reconsideration	A reconsideration is the first level of the appeal process. Reconsiderations involve a Part C plan reevaluating an adverse organization determination (denial of coverage/payment). The reviewer on the redetermination is different from the person who made the initial organization determination.

Part C
Appeals & Grievances Process



NOTE The 60 day filing timeline for the first level appeal does not start until the adverse determination (denial) is made by GlobalHealth.

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Part D Appeals & Grievances

Term	Definition
Appeal	An appeal is any of the procedures that deal with the review of an adverse organization determination (denial of coverage/payment) made by the plan on the benefits or on any amounts the enrollee must pay for the drug coverage.
Coverage Determination	A coverage determination is any decision made by, or on behalf of, a Part D plan sponsor regarding payment benefits to which an enrollee believes he/she is enrolled.
Grievance	A grievance is any complaint or dispute, other than a coverage determination or Late Enrollment Penalty (LEP) determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.
Redetermination	A redetermination is the first level of the appeal process. Redeterminations involve a Part D plan reevaluating an adverse organization determination (denial of coverage/payment). The reviewer on the redetermination is different from the person who made the initial coverage determination.

NOTE

The appeals process is different for Part D services than Part C.

The next slide details the Part D appeal process

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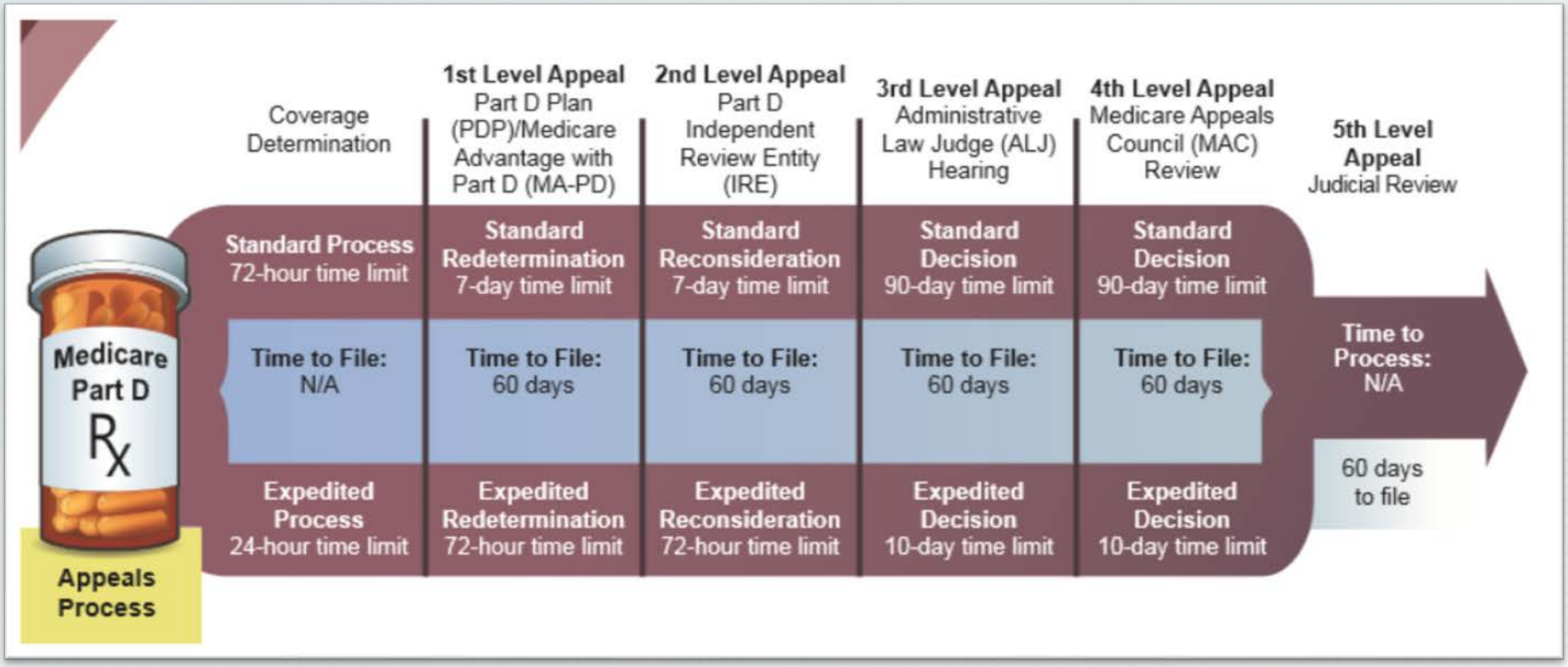
Part D
Appeals & Grievances Process



NOTE The 60 day filing timeline for the first level appeal does not start until the adverse determination (denial) is made by GlobalHealth.

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Eligibility & Service Area Overview

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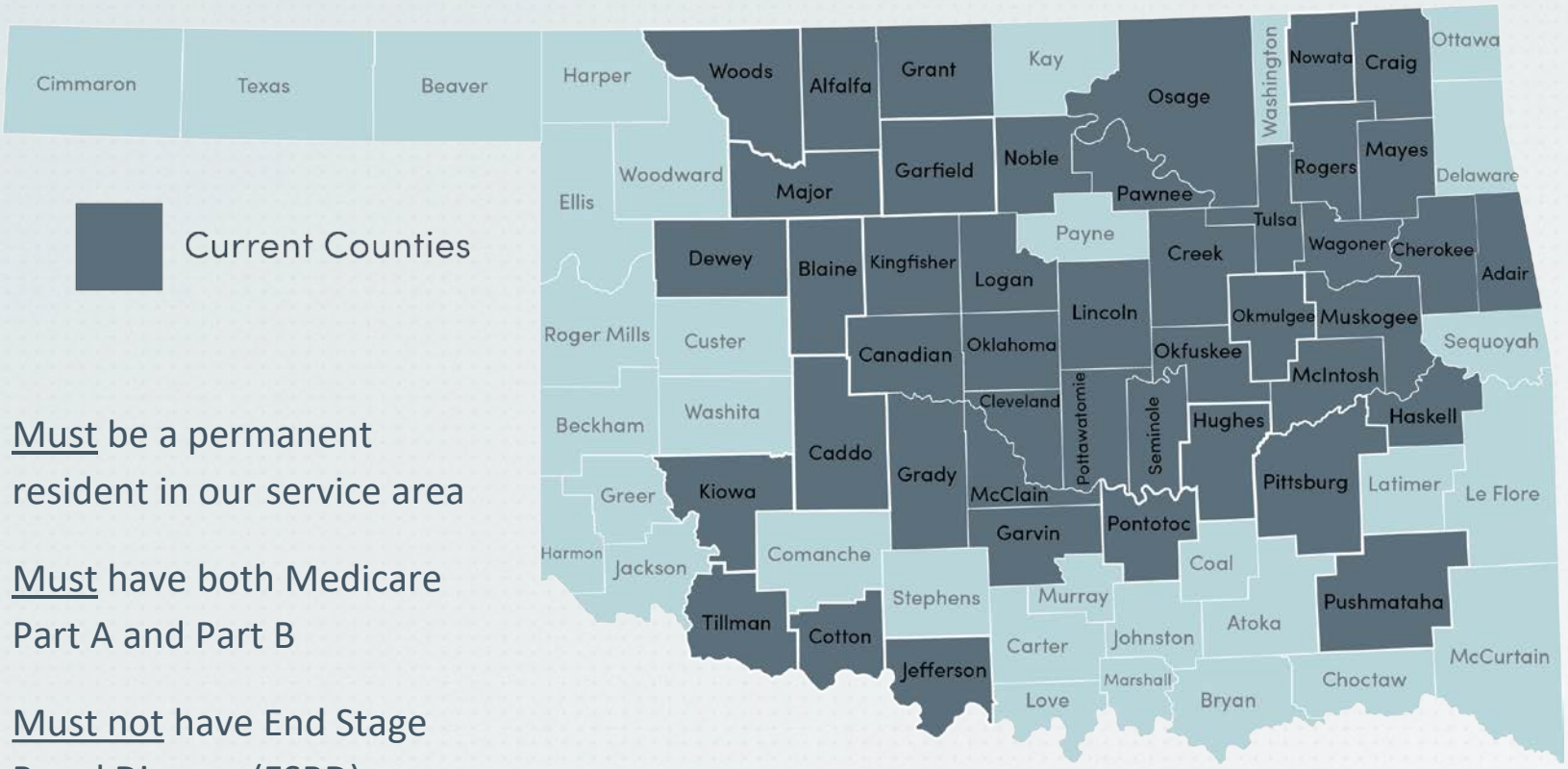
Eligibility & Service Area



- Must be a permanent resident in our service area
- Must have both Medicare Part A and Part B
- Must not have End Stage Renal Disease (ESRD)

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2020 Plan Options

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2020 Medicare Advantage Plans

MA Only

- Generations Value (HMO) – $0 monthly premium

MA-PD

- Generations Classic (HMO) – $0 monthly premium
- Generations Select (HMO) – $28 monthly premium

NOTE Members must continue to pay their Medicare Part B premium.

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2020 Medicare Advantage Plans

MA Only Plan

BENEFIT	GENERATIONS VALUE
Monthly Premium	$0
Deductible	No deductible
Maximum Out-of-Pocket (“MOOP”)	$3,000 copay
Primary Care Physician - PCP	$0 copay
Specialist	$40 copay/visit - no referral or PA required for OB/GYN office visits
Outpatient Surgery (Waived if admitted to acute care.)	$250 copay – Ambulatory Surgery Center $320 copay– Hospital
Inpatient Hospital Care	$250 copay/day– (Days 1 – 5) $0 copay– (Days 6 – 190)
Outpatient Diagnostic Tests (Labs, X-rays, etc.)	$0 copay– for labs and X-rays $100 copay– sleep studies in outpatient facility
Outpatient Diagnostic Radiology Tests – (Diagnostic Radiology (MRI, etc.))	$180 copay/visit in PCP or specialist office, urgent care center, or preferred (non-hospital based) radiology facility (this amount is added to the office visit or urgent care copay) $250 copay/visit in non-preferred (hospital based) radiology facility
Emergency Room (Waived if admitted to hospital or outpatient surgery or observation within 24 hours.)	$75 copay
Urgent Care	$15 copay/visit

NOTE Please see the EOC for a full list of benefits covered by GlobalHealth

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Generations Value (HMO)

IMPORTANT:
Prescription Drug Coverage is NOT included with the Generations Value plan.

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2020 Medicare Advantage Plans

MA-PD Plans

BENEFIT	GENERATIONS CLASSIC	GENERATIONS SELECT
Monthly Premium	$0	$28
Deductible	No deductible	No deductible
Maximum Out-of-Pocket (“MOOP”)	$3,400	$3,400
Primary Care Physician - PCP	$0 copay	$0 copay
Specialist	$40 copay/visit	$35 copay/visit
Outpatient Surgery (Waived if admitted to acute care.)	$250 copay – Ambulatory Surgery Center $320 copay – Hospital	$250 copay – Ambulatory Surgery Center $320 copay – Hospital
Inpatient Hospital Care	$395 copay/day – (Days 1 – 5) $0 copay – (Days 6 – 190)	$345 copay/day – (Days 1 – 5) $0 copay – (Days 6 – 190)
Outpatient Diagnostic Tests (Labs, X-rays, etc.)	$0 copay – for labs and X-rays $100 copay – sleep studies in outpatient facility	$0 copay - for labs and X-rays $100 copay – sleep studies in outpatient facility
Outpatient Diagnostic Radiology Tests (Diagnostic Radiology (MRI, etc.))	$180 copay/visit in PCP or specialist office, urgent care center, or preferred (non-hospital based) radiology facility $250 copay/visit in non-preferred (hospital based) radiology facility	$180 copay/visit in PCP or specialist office, urgent care center, or preferred (non-hospital based) radiology facility $250 copay/visit in non-preferred (hospital based) radiology facility
Emergency Room (Waived if admitted to hospital or outpatient surgery within 24 hours.)	$120 copay	$85 copay
Urgent Care	$30 copay	$25 copay

NOTE Please see the EOC for a full list of benefits covered by GlobalHealth

GENERATIONS MEDICARE ADVANTAGE PLANS

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2020 Prescription Drug Coverage

30-DAY PREFERRED RETAIL OR MAIL ORDER	GENERATIONS CLASSIC (HMO)	GENERATIONS SELECT (HMO)
Tier 1 Preferred Generics	$5 copay	$3
Tier 2 Generics	$15 copay	$13
Tier 3 Preferred Brand Name	$42 copay	$40
Tier 4 Non-Preferred Drugs	40% coinsurance	40% coinsurance
Tier 5 Specialty Drugs	33% coinsurance	33% coinsurance

90-DAY PREFERRED RETAIL OR MAIL ORDER	GENERATIONS CLASSIC (HMO)	GENERATIONS SELECT (HMO)
Tier 1 Preferred Generics	$0 copay	$0 copay
Tier 2 Generics	$0 copay	$0 copay
Tier 3 Preferred Brand Name	$84 copay	$80 copay
Tier 4 Non-Preferred Drugs	40% coinsurance	40% coinsurance

NOTE

- Cost sharing is higher at standard pharmacies. See the Pharmacy Directory to see which pharmacies offer preferred cost sharing.
- Part D member cost-shares **do not** count towards the member's Maximum-out-of-Pocket (MOOP).

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Understanding Part D Payment Stages for 2020

Deductible Stage

Member pays the full cost of his drugs until the deductible is met.*

*NO deductible on our plans.

Initial Coverage Stage

The plan pays its share of the cost and member pays his share of the cost (copayment or coinsurance) for each prescription filled until the total drug costs (what the member pays plus what GlobalHealth pays) reach $4,020.

Coverage Gap Stage

Member will pay no more than 25% for covered generics or 25% on brand drugs until member's out-of-pocket drug costs reach $6,350.

Catastrophic Coverage Stage

Member will pay the greater of 5% of the drug cost or $3.60 for generics and $8.95 for all other drugs.

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Prescription Drug Stages

Stage 1 Yearly Deductible Stage	Stage 2 Initial Coverage Stage	Stage 3 Coverage Gap Stage ("The Donut Hole")	Stage 4 Catastrophic Coverage Stage
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,020. (Details are in Chapter 6, Section 5 of the Evidence of Coverage.)	For Tier 1 generic drugs, you pay either the same copayment as in the Initial Coverage Stage or 25% of the costs, whichever is lower. For Tier 1 brand name drugs and Tier 3 oral anti-diabetic drugs, you pay either the same copayment as in the Initial Coverage Stage or 25% of the price (plus a portion of the dispensing fee), whichever is lower. For other tiers, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the costs for generic drugs. You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $6,350. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Chapter 6, Section 6 of the Evidence of Coverage.)	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Chapter 6, Section 7 of the Evidence of Coverage.)

Prescription Drug Tiers

Tier 1 (Preferred Generic Drugs)

- Tier 1 includes preferred brand and generic drugs.

Tier 2 (Generic Drugs)

- Tier 2 includes brand and generic drugs.

Tier 3 (Preferred Brand-Name Drugs)

- Tier 3 includes preferred brand drugs and non-preferred generic drugs.

Tier 4 (Non-Preferred Drugs)

- Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.

Tier 5 (Specialty Drugs)

- Tier 5 contains very high cost brand and generic drugs, which may require special handling and/or close monitoring.

Coverage Gap Stage

Tier 1 Generic Drugs:

- The member pays either the same amount as in the Initial Coverage Stage or 25% of the cost, whichever is less.
- Members pay 25% of the cost for generics in other tiers.

Tier 1 Brand Drugs or Tier 3 Oral Antidiabetic Drugs:

- The member pays either the same amount as in the Initial Coverage Stage or 25% of the cost plus a portion of the dispensing fee, whichever is less, for brand name drugs in Tier 1.
- The member pays either the same amount as in the Initial Coverage Stage or 25% of the cost plus a portion of the dispensing fee, whichever is less, for oral anti-diabetic medications (not insulin) in Tier 3.
- Members pay 25% of the cost plus a portion of the dispensing fee for other brand name drugs.

Additional Part D Coverage Requirements

Some covered drugs may have additional requirements or limits on coverage:

- Step Therapy – for certain formulary prescription drugs that first require trial and failure of other formulary alternatives.
- Prior Authorization – for certain formulary prescription drugs that require plan approval before the prescription drug is covered.
- Quantity Limit – for certain medications that have quantity limits to the amount of drug covered.
- Medicare Part B vs. Medicare Part D determination of coverage.

Supplemental Benefits

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Medicare-covered Vision Benefits

Medicare covers exams and treatment for diseases and injuries of the eye. All beneficiaries are covered.

Supplemental Vision Benefits

Benefit	GENERATIONS VALUE	GENERATIONS CLASSIC	GENERATIONS SELECT
Yearly routine eye exam not related to disease or injury	**$0 copay**	**$0 copay**	**$0 copay**
Eyeglasses or contact lenses not related to cataract removal	• **GlobalHealth pays up to $200** • **The member pays the remaining amount**	• **GlobalHealth pays up to $200** • **The member pays the remaining amount**	• **GlobalHealth pays up to $200** • **The member pays the remaining amount**

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Medicare-covered Dental Benefits

Medicare covers dental care related to a medical condition. Services are usually performed in an inpatient or outpatient surgical setting.

- Jaw fracture
- Tooth removal before cancer treatment
- Reconstruction of a ridge performed as a result of and at the same time as the surgical removal of a tumor

GlobalHealth

Supplemental Dental Benefits

ALL GENERATIONS PLANS

Preventive Care:

Two visits per year – oral exam, cleaning, and dental x-rays

Comprehensive Care:

- Non-routine services (such as oral surgery in a dental office)
- Diagnostic services (such as x-rays other than bitewing)
- Restorative services (such as fillings and crowns)
- Endodontics (such as root canals)
- Periodontics (such as scaling and root planing)
- Extractions
- Prosthodontics (such as dentures and bridges)

Plan Allowance toward all preventive care and comprehensive services:

- Generations Value and Generations Classic - $1,000
- Generations Select - $900
- The member pays the remaining amount

Network:

Members must use network dentists (https://www.globalhealth.com/provider-search

GlobalHealth

Medicare-covered Hearing Benefits

Medicare covers exams and treatment for diseases and injuries of the ear. All beneficiaries are covered.

Supplemental Hearing Benefits

Benefit	GENERATIONS VALUE	GENERATIONS CLASSIC	GENERATIONS SELECT
Yearly routine hearing exam not related to disease or injury	**$0 copay**	**$0 copay**	**$0 copay**
Hearing aids with related adjustments and fittings	• **GlobalHealth pays up to $500** • **The member pays the remaining amount**	• **GlobalHealth pays up to $500** • **The member pays the remaining amount**	• **GlobalHealth pays up to $500** • **The member pays the remaining amount**

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Supplemental Over-the-Counter (OTC) Benefit

ALL GENERATIONS PLANS

$50 Quarterly allowance toward CVS catalog purchase

- *Must include all items in one order per quarter*
  - If the entire allowance is not used, the member **will not** have the remaining balance to use later
  - Cannot order more than the allowance
- GlobalHealth pays shipping and sales tax
- Member must order from the catalog, either by calling or going online – a separate card is not issued for the OTC benefit and the member may not use in-store.

Find the catalog and other information on our website

- Go to the Member Materials page
- Look under Pharmacy Documents, Links and Resources, Over the Counter Benefit
- https://globalhealth.com/medicare-advantage/member-materials

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Supplemental Fitness Benefit

ALL GENERATIONS PLANS

Silver&Fit® Exercise and Health Aging Program

- Members have the following choices available at no cost to them:
  - A fitness center membership – go to a Silver&Fit fitness club, YMCA, or other exercise center that takes part in the program
  - A home fitness program – Members that can't go to a fitness center may choose from a variety of fitness kits, up to 2 kits per year
- Membership includes Healthy Aging classes (online or DVD), a quarterly newsletter, and web tools

Find the information on our website

- Go to the Member Materials page
- Look under Pharmacy Documents, Links and Resources, Over the Counter Benefit
- https://globalhealth.com/medicare-advantage/other-benefits/fitness-benefit/

GlobalHealth

Additional Help with Certain Chronic Conditions

ALL GENERATIONS PLANS

Transportation benefit:
Six round trips to doctor visits per year
• Members with one or more of the following diagnoses are eligible:
  • Chronic Obstructive Pulmonary Disease
  • Coronary Artery Disease
  • Diabetes
  • Heart Disease
  • Hypertension
  • Blindness
• GlobalHealth case managers will arrange the ride to and from a doctor visit

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Additional Help with Certain Chronic Conditions

ALL GENERATIONS PLANS

Meal delivery benefit:
Two meals per day for five days, up to 4 times per year following inpatient hospitalization or skilled nursing facility discharge
• Members with one or more of the following diagnoses are eligible:
  • Chronic Obstructive Pulmonary Disease
  • Coronary Artery Disease
  • Diabetes
  • Heart Disease
  • Hypertension
  • Blindness
• GlobalHealth case managers will arrange the meal delivery

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Provider & Pharmacy Network

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Provider Directory & Pharmacy Directory

Agents should always use the online search tool for *up-to-date* provider and pharmacy information
Providers - http://www.globalhealth.com/provider-search/
Pharmacies - https://www.globalhealth.com/pharmacy-directories/
Or, call Customer Care at 844-280-5555.

Agents:

- To locate a provider, you can search by zip, county and/or physician name.
- To locate a pharmacy, choose “Click here for the most current list of participating Pharmacies.” You can then search by zip code, name, or type.

Members:

- Members will receive a Welcome Kit upon enrollment, including their EOC Notice, Provider Directory Notice, Pharmacy Directory Notice, Formulary Notice (for MAPD plans), Star Ratings, and Advance Directive Information.
- The directories can be accessed on our website at the links above.

NOTE The Provider Directory is subject to change at any time. Members will receive notice when necessary.

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Additional Resources

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Plan Materials

Plan-specific materials are available on our website (https://globalhealth.com/medicare-advantage/member-materials) :

- Annual Notice of Change
- Evidence of Coverage
- Drug Formulary
- Provider Directory
- Pharmacy Directory
- Summary of Benefits

Please always refer to the Evidence of Coverage and other appropriate materials for full product descriptions. For training assistance on GlobalHealth products, policies and procedures, please email agenthotline@globalhealth.com or call 918-878-7316.

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Additional Contact Information

If you have a compliance concern:

- Email compliance@globalhealth.com
- Call GlobalHealth's toll-free Hotline @ 1-877-280-5852

If you have a privacy concern:

- Email privacy@globalhealth.com
- Call GlobalHealth's toll-free Hotline @ 1-877-280-5852

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.

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DEFINITIONS

Term	Definition
Coinsurance	A percentage amount that a member may be required to pay as their share of the cost for services after any required deductibles are paid. Coinsurance is usually a percentage of the total approved amount paid to the provider for services provided.
Copayment	A fixed amount members are required to pay as their share of the cost of a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription. The copayment is paid when the service is provided.
Deductible	An amount a member must pay out of pocket for medical services before the plan begins to pay.
Maximum Out-of-Pocket Limit	The yearly out-of-pocket maximum is the highest or total amount a health plan requires a member to pay towards the cost of healthcare for that calendar year.
Medically Necessary	Drugs, services or supplies that are medically necessary for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and, are not mainly for convenience.
Network Provider	Any doctor, healthcare professional, medical group, hospital or other healthcare facility that has an agreement with GlobalHealth to accept the plan's payment and the member's cost-sharing amount as payment in full.

DEFINITIONS

Term	Definition
Out-of-Network (OON) Provider	A Medicare provider who does not have an agreement with the plan to accept the plan's payment and the member's cost-sharing amount as payment in full. Providers must be participating in Medicare to be considered for Out-of-Network care.
Prior Authorization	A requirement for prior authorization from the plan for some covered services including inpatient hospital admissions, specialists, inpatient and outpatient surgical, diagnostics, and all services provided by out-of-network providers. These services are listed on the Evidence of Coverage Medical Benefits Chart.
Primary Care Physician (PCP)	A doctor, contracted with the plan, who meets state licensing requirements and is trained to provide basic medical care.
Referral	A written order from the PCP to see a specialist or to get certain medical services such as skilled nursing services or home healthcare services.
Specialist	A healthcare professional who provides healthcare services for a specific disease or part of the body.
True Out-of-Pocket Costs (TrOOP)	A yearly calculation of what members have paid for Part D prescription drugs while on a Medicare Advantage Prescription Drug plan, including any deductibles and copays. When TrOOP costs reach a specific dollar amount, members become eligible for catastrophic coverage, which allows members to get medicines at a lower cost.
Urgently-Needed Care	A non-emergency situation when a member needs medical care right away because of an illness, injury or condition that he/she did not expect or anticipate, but his/her health is not in immediate danger.