GlobalHealth

Generations Medicare Advantage Plans

2020 Summary of Benefits

January 1 – December 31, 2020

Supporting generations of your best health.

Generations Medicare Advantage Plan Options:

Generations Value (HMO)

Generations Classic (HMO)

Generations Select (HMO)

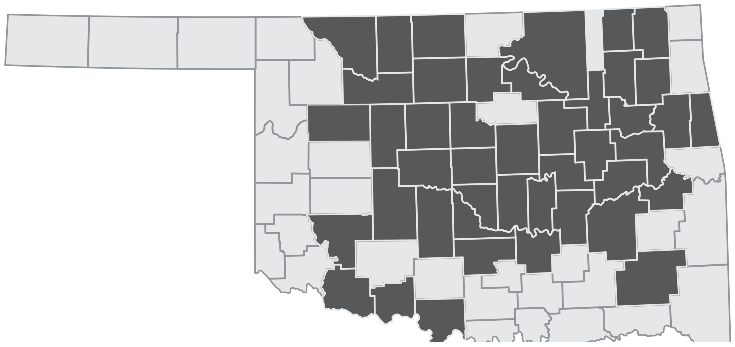
1-844-280-5555 (TTY: 711)
8 a.m. to 8 p.m.
7 days a week (October 1 - March 31)
Monday - Friday (April 1 - September 30)
www.GlobalHealth.com/medicare

H3706_SB_PY2020_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: 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	Creek	Kingfisher	Noble	Pottawatomie
Alfalfa	Dewey	Kiowa	Nowata	Pushmataha
Blaine	Garfield	Lincoln	Okfuskee	Rogers
Caddo	Garvin	Logan	Oklahoma	Seminole
Canadian	Grady	Major	Okmulgee	Tillman
Cherokee	Grant	Mayes	Osage	Tulsa
Cleveland	Haskell	McClain	Pawnee	Wagoner
Cotton	Hughes	McIntosh	Pittsburg	Woods
Craig	Jefferson	Muskogee	Pontotoc	

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: 711), or visit us at www.GlobalHealth.com.

2020

Medicare Advantage Plan

Without Prescription Drug Coverage

(No Medicare Part D)

Generations Value (HMO) Summary of Benefits

January 1, 2020 – December 31, 2020

Plans may offer supplemental benefits in addition to Part C benefits and Part D 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**	• You pay nothing • You pay $40 copay per visit	

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 $15 copay per visit	
Ambulatory Surgery Center	You pay $250 copay per visit; waived if admitted to acute care	
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 $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a nonpreferred setting • 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** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $40 copay per visit • You pay nothing • You pay nothing	Routine exam is limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Dental Services **• Preventive Dental Services** **• Oral exam (2 per year)** **• X-rays (2 sets per year)** **• Cleaning (2 per year)** **• Comprehensive Dental Services** **• Non-routine services** **• Diagnostic services** **• Restorative services** **• Endodontics** **• Periodontics** **• Extractions** **• Medicare-covered exams[1,2]**	• You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays up to a total of $1,000 for preventive and comprehensive dental services per year, including dentures.
Vision Services **• Medicare-covered eye exam** **• Supplemental eye exam (1 per year)** **• Supplemental eyeglasses (frames and lenses) or contacts** **• Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay nothing • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 pair of supplemental eyeglasses or contacts. 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 (SNF)[1,2]	• You pay nothing per day (Days 1-20); You pay $178 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. If these services are provided in your home, then the home health cost-sharing applies instead.

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2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS VALUE	WHAT YOU SHOULD KNOW
Ambulance	You pay $150 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	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
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**	• 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 per visit	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $30 copay per visit • You pay $30 copay per visit	Routine foot care is limited to members with certain medical conditions affecting the lower limbs.

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2 = Referral Required

2020

Medicare Advantage Prescription Drug (MA-PD) Plans

Generations Classic (HMO) Summary of Benefits

January 1, 2020 – December 31, 2020

Plans may offer supplemental benefits in addition to Part C benefits and Part D 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 $395 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**	• You pay nothing • You pay $40 copay per visit	
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 $120 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.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Ambulatory Surgery Center	You pay $250 copay per visit; waived if admitted to acute care	
Urgently Needed Services	You pay $30 copay per visit	
Diagnostic Services/Labs/Imaging • **Diagnostic radiology service (e.g., MRI)**[1,2] • **Lab services** • **Diagnostic tests and procedures** • **Therapeutic Radiology**[1,2] • **Outpatient x-rays**	• You pay $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a nonpreferred setting • 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** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $40 copay per visit • You pay nothing • You pay nothing	Routine exam limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.
Dental Services • **Preventive Dental Services** • **Oral exam (2 per year)** • **X-rays (2 sets per year)** • **Cleaning (2 per year)** • **Comprehensive Dental Services** • **Non-routine services** • **Diagnostic services** • **Restorative services** • **Endodontics** • **Periodontics** • **Extractions** • **Medicare-covered exams** [1,2]	• You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays a total of $1,000 for preventive and comprehensive dental services per year, including dentures.

PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Vision Services • **Medicare-covered eye exam** • **Supplemental eye exam** • **Supplemental eyeglasses (frames and lenses) or contacts** • **Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay nothing • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts. 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 (SNF)[1,2]	• You pay nothing per day (Days 1-20); You pay $178 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	If these services are provided in your home, then the home health cost-sharing applies instead.
Ambulance	You pay $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.

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PREMIUMS AND BENEFITS	GENERATIONS CLASSIC	WHAT YOU SHOULD KNOW
Transportation	Not covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
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**	• 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 per visit	
Foot Care (podiatry services) • **Foot exams and treatment** • **Routine foot care**	• You pay $30 copay per visit • You pay $30 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 Retail and Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $5 copay per fill	You pay $10 copay per fill	You pay nothing	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 nothing	
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 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	
Phase 3: Coverage Gap Stage After your prescription costs reach $4,020	For generic drugs in Tier 1, you pay either the same copayment as the Initial Coverage Stage or 25% of the costs, whichever is lower. For brand name drugs in Tier 1, you pay either the same copayment as the initial coverage stage or 25% of the price (plus a portion of the dispensing fee), whichever is lower. For oral anti-diabetics in Tier 3, you pay either the same copayment as the Initial Coverage Stage or 25% of the costs (plus a portion of the dispensing fee), whichever is lower. For all other generic drugs, you pay 25% of the costs. For all other brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee).			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.
Phase 4: Catastrophic Coverage Stage After you have paid $6,350 out-of-pocket	You pay the greater of 5% of the cost of the drug or $3.60 for generics/$8.95 for brand names.			

PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. 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 Pharmacy

Generations Select (HMO) Summary of Benefits

January 1, 2020 – December 31, 2020

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Monthly Plan Premium, including Part C and Part D premium	You pay $28	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 $345 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 $150 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**	• You pay nothing • You pay $35 copay per visit	

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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	
Ambulatory Surgery Center	You pay $250 copay per visit; waived if admitted to acute care	
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 $180 copay per visit in a PCP, specialist, urgent care, or preferred setting; You pay $250 copay per visit in a nonpreferred setting • 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 vist** • 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** • **Routine exam** • **Hearing aids**	• You pay nothing • You pay $25 copay per visit • You pay nothing • You pay nothing	Routine exam limited to 1 per year. Our plan pays up to a total of $500 for hearing aids per year.

1 = Prior Authorization Required
2 = Referral Required

PREMIUMS AND BENEFITS	GENERATIONS SELECT	WHAT YOU SHOULD KNOW
Dental Services **• Preventive Dental Services** **• Oral exam (2 per year)** **• X-rays (2 sets per year)** **• Cleaning (2 per year)** **• Comprehensive Dental Services** **• Non-routine services** **• Diagnostic services** **• Restorative services** **• Endodontics** **• Periodontics** **• Extractions** **• Medicare-covered exams[1,2]**	• You pay nothing • You pay nothing • You pay based on setting (doctor's office, emergency room, etc.)	Our plan pays up to a total of $900 for preventive and comprehensive dental services per year, including dentures.
Vision Services **• Medicare-covered eye exam** **• Supplemental eye exam** **• Supplemental eyeglasses (frames and lenses) or contacts** **• Eyeglasses or contact lenses after cataract surgery**	• You pay nothing • You pay nothing • You pay nothing • You pay nothing	Supplemental eye exam limited to 1 per year. Choice of 1 supplemental eyeglasses or contacts. 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 (SNF)[1,2]	• You pay nothing per day (Days 1-20); You pay $178 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	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 $250 copay per occurrence	One-way trip. If you are admitted to the hospital, you do not have to pay your share of the cost for ambulance services.
Transportation	Not covered	See "Help with Certain Chronic Conditions" in the Evidence of Coverage for transportation services provided for beneficiaries with certain chronic illnesses.
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**	• 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 per visit	
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 Retail and Mail Order 90-day supply***	
Tier 1: Preferred Generic	You pay $3 copay per fill	You pay $8 copay per fill	You pay nothing	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-day 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 $13 copay per fill	You pay $18 copay per fill	You pay nothing	
Tier 3: Preferred Brand	You pay $40 copay per fill	You pay $45 copay per fill	You pay $80 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	
Phase 3: Coverage Gap Stage After your prescription costs reach $4,020		For generic drugs in Tier 1, you pay either the same copayment as the Initial Coverage Stage or 25% of the costs, whichever is lower. For brand name drugs in Tier 1, you pay either the same copayment as the initial coverage stage or 25% of the price (plus a portion of the dispensing fee) whichever is lower. For oral anti-diabetics in Tier 3, you pay either the same copayment as the Initial Coverage Stage or 25% of the costs (plus a portion of the dispensing fee), whichever is lower. For all other generic drugs, you pay 25% of the costs. For all other brand name drugs, you pay 25% of the price (plus a portion of the dispensing fee).		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.
Phase 4: Catastrophic Coverage Stage After you have paid $6,350 out-of-pocket		You pay the greater of 5% of the cost of the drug or $3.60 for generics/$8.95 for brand names.		

PLEASE NOTE: Please visit our website for the most up-to-date drug formulary. 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 Pharmacy

Customer Care: 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/medicare-advantage/member-materials

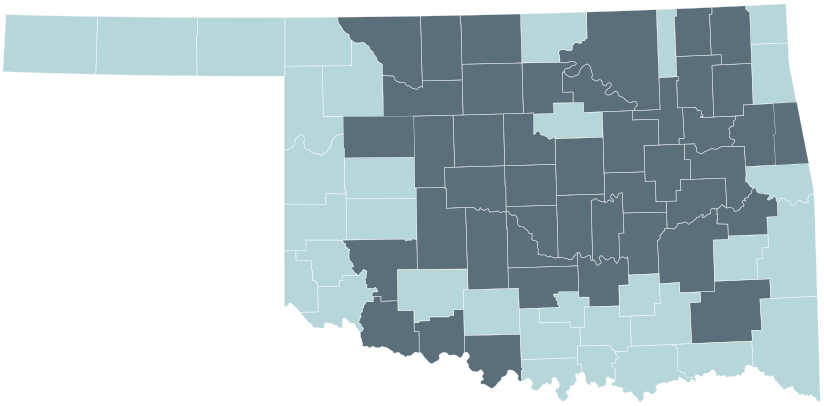
Provider Directory: www.GlobalHealth.com/search
Pharmacy Directory: www.GlobalHealth.com/pharmacy-directory

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at www.GlobalHealthMedicare.com.

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

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.

2020 Service Area



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

GlobalHealth
Generations Medicare Advantage Plans

For questions or to enroll:
1-844-322-8322 (TTY: 711)
www.GlobalHealthMedicare.com

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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