BlueCross BlueShield of Oklahoma

Welcome Guide

Important information about your retiree Medicare Advantage plan

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When you get information from your **BCBSOK-MAPD℠ plan**, look for these helpful icons to get the most out of your plan.

When you see this icon, **TAKE ACTION** to complete a task.

When you see this icon, **SAVE THIS** important information somewhere you can easily reference it.

When you see this icon, you have **NEW INFORMATION** to review.

Live your Blue life

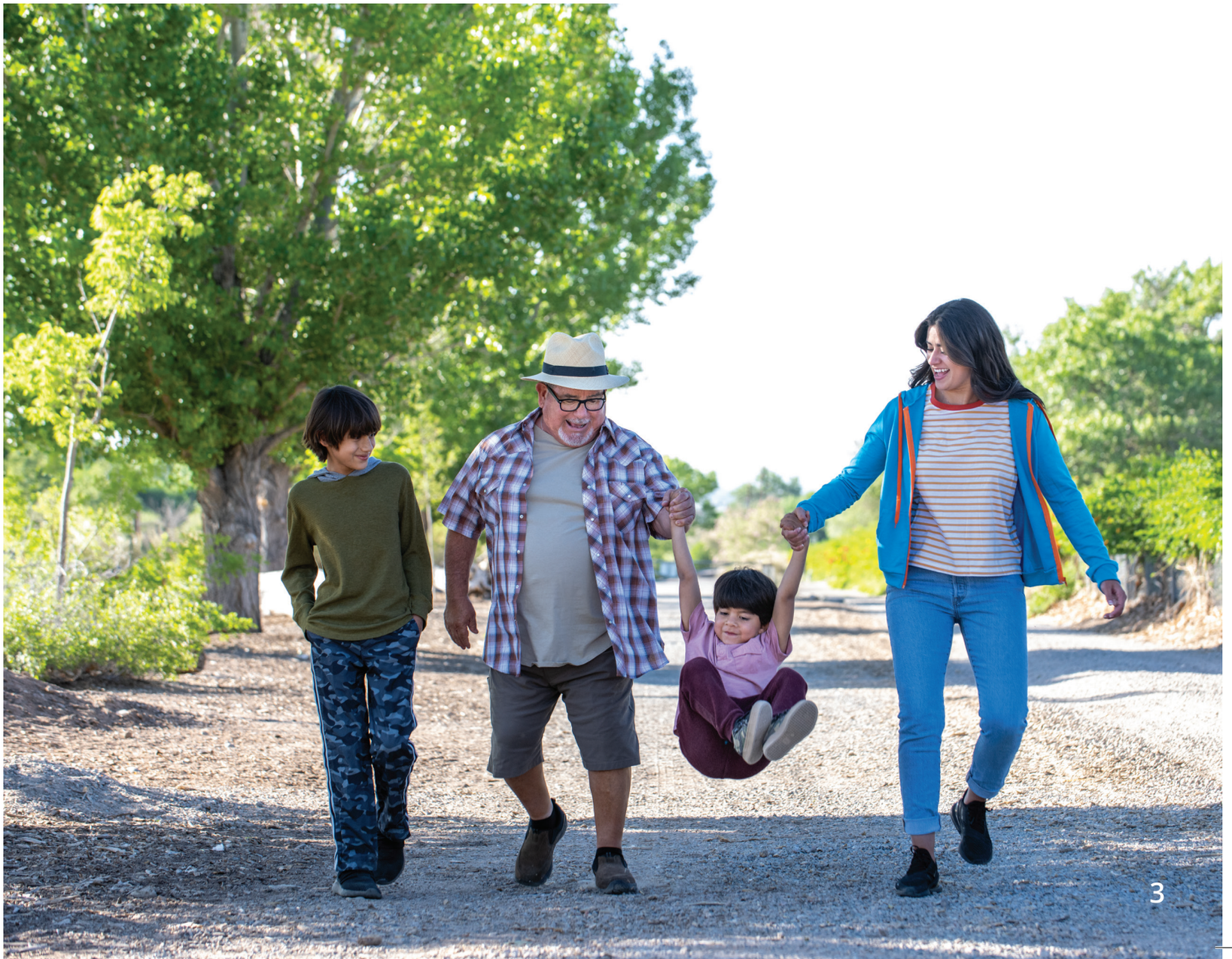
Welcome to BCBSOK-MAPD.

Our goal is to help our Medicare members manage their health. It's why we've developed this Welcome Guide.

It includes useful information like:

- Using your member ID card.
- Understanding your plan's coverage.
- Exploring your wellness solutions.
- Getting help when you need it.

Please review the information about your coverage and next steps, starting on page 4.



Let's Get Started

Follow these easy steps to get the most from your plan.

Step 1 Check Your Member ID Card

You can use your benefits starting on your effective date.

Use your Blue Cross and Blue Shield of Oklahoma member ID card whenever you receive a service or benefit covered by your plan, including prescription drugs. Upon receiving your ID card, you will want to review the following:

- **Effective date**
  Your confirmation letter will show your effective date — the date your coverage begins. The letter can be used as proof of insurance if you have not received your member ID card by your effective date.
- **Personal information**
  Make sure the information on the member ID card is accurate. If you have any questions or concerns, call Customer Service.

If something is wrong on your ID card, please call the Customer Service number on the back of the card.

Step 2 Sign up or Log in to Blue Access for Members

Everything you need to know about your coverage — in one place.

Get the most out of your health care benefits with Blue Access for Members (BAM[SM]), a secure website and mobile app. It's the health information you need, any time you need it. If you already have a BAM account, you do not need to set up a new one.

Here are a few things you can do with BAM:

- View your claims status and up to 18 months of claims activity.
- See your prescription history.
- Search for a health care provider, hospital, urgent care facility or pharmacy.
- Compare providers on a single page — you can view and sort providers by quality, cost and accessibility.
- Request or print your ID card.
- View or print Explanation of Benefits statements.
- And more!

Go mobile! It's Easy to Get Started!

Grab your smartphone and ID card and text* BCBSOKAPP to 33633 to download the mobile app so you can use BAM while you're on the go, or go to **www.bluememberok.com**.

* Message and data rates may apply.

Step 3 Understand Your Plan's Network

Selecting a provider.

Your Medicare Advantage Open Access PPO plan gives you the freedom to seek care across the country. You can use network providers but have the flexibility to go outside the network for the same cost. No referral is needed. Your providers must 1) accept Medicare; 2) agree to see you as a patient; and 3) agree to submit claims to the plan.*

Call ahead and be prepared.

Calling your provider's office ahead will help make sure:

- All your information is up to date.
- The provider is still accepting Medicare.

We recommend that you confirm with providers that they accept your Medicare Advantage Open Access PPO plan and will submit claims to the plan. At your appointment, show the provider the 'Your Providers, Your Personal Network' flyer that is included with this Welcome Guide. Detailed plan information, including cost-sharing that applies to out-of-network services, can be found in your Evidence of Coverage Benefit Insert.

We work closely with your provider to deliver care.

Before you can be covered for some medications or certain high-cost medical services, your doctor may need to get authorization from the plan. You may first need to try other clinically appropriate or cost-effective treatments. Quantity limits may be set for some drugs for cost or safety reasons.

Our plans follow government guidelines in this area to ensure you receive the most appropriate, cost-effective care available.

Please note: It's important to give your doctor the full name of your specific Medicare Advantage plan and network and not just say you have Blue Cross and Blue Shield, since many physicians are usually part of more than one Blue Cross and Blue Shield network. This information is located on your member ID card.

Be sure to tell the provider's office that you are in a Group Medicare Advantage Open Access PPO plan.

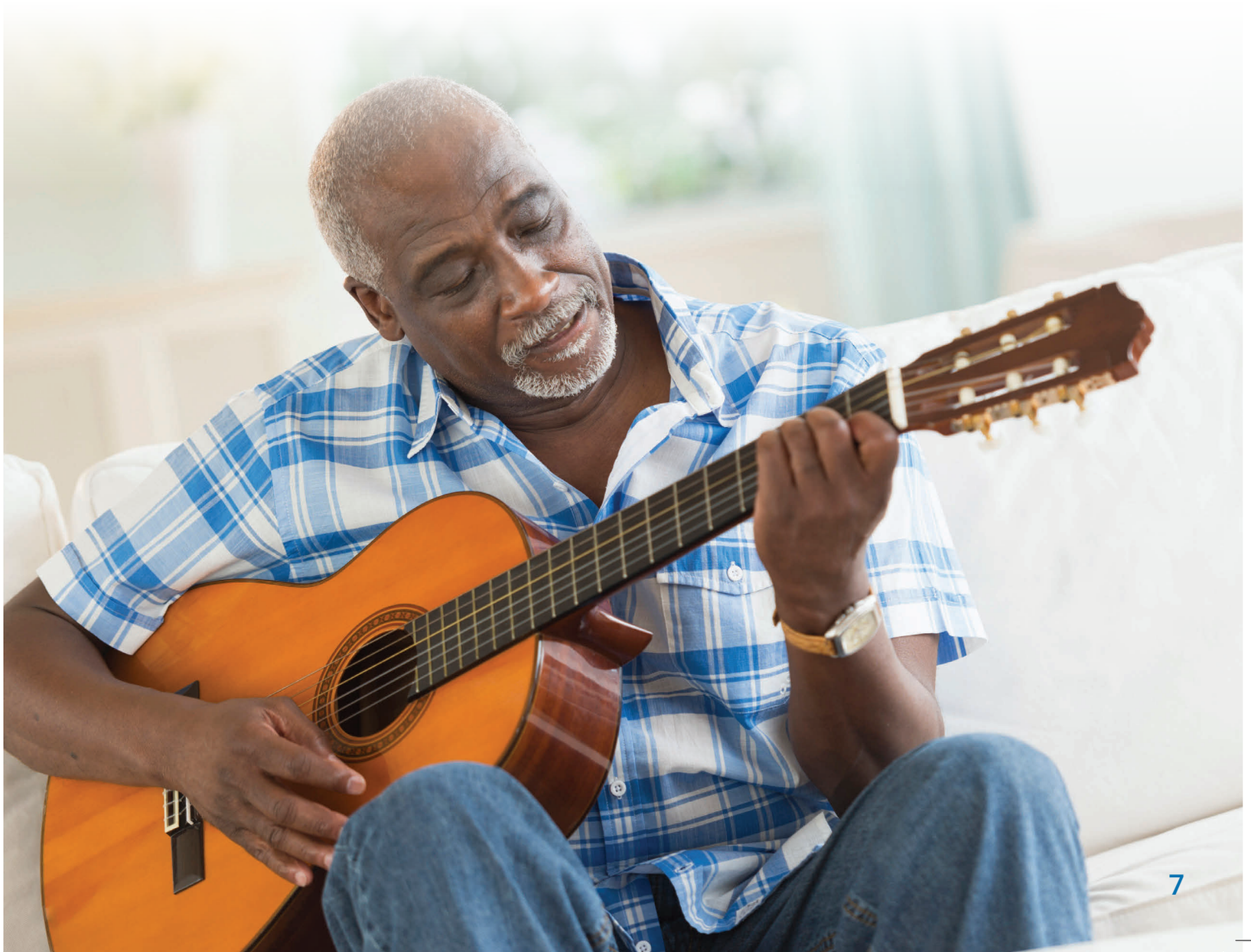
*Out-of-network/non-contracted providers are under no obligation to treat BCBSOK members, except in emergency situations.

Step 4 Review Your Evidence of Coverage (EOC) Benefit Insert (EBI)

The EBI in this guide explains:

- Your rights and responsibilities.
- What's covered.
- What you pay as a member of the plan.

We encourage you to review your EBI. It lists the coverage, costs and extra health and wellness benefits that are provided by your retiree Medicare plan. It's an important legal document, so keep it in a safe place. It is part of your complete EOC which can be found on BAM (see Step 2).



Step 5 Schedule Your Annual Wellness Visit

Wellness begins with understanding.

Your BCBSOK-MAPD plan includes a $0 copay Annual Wellness Visit with your health care provider. Use this checklist to guide the conversation. Schedule your Annual Wellness Visit today and earn rewards through our Rewards Program*. Earn up to $100 in gift cards from national and local retailers for completing your Annual Wellness Visit and additional preventive screenings (as indicated with $). Additional information on our Rewards Program can be found on page 14.

Talk With Your Doctor About	Completion Date / Notes
☐ All your current conditions and treatments	
☐ Prescription and over-the-counter medications	
☐ Any pain you have and what you do for it	
☐ Difficulties with daily activities	
☐ Your level of physical exercise	
☐ Balance issues or recent falls $	
☐ Difficulties with bladder control	
☐ Problems with sleeping or memory loss	
☐ Tobacco, alcohol or drug use	
☐ Hospital or ER visits in the last 90 days	
Complete These Basic Exams	**Completion Date / Notes**
☐ Blood Pressure	
☐ Height, Weight and Body Mass Index (BMI)	
☐ Blood Sugar and Retinal Eye Exam (if applicable) $	
Review Your Screenings and Vaccines	**Completion Date / Notes**
☐ Annual Flu Vaccine $	
☐ Bone Density Exam $	
☐ Colorectal Screening $	
☐ Mammogram $	
☐ Pneumonia Vaccine	

*The Healthy Activity Portal is a website owned and operated by HealthMine, Inc., an independent company that has contracted with Blue Cross and Blue Shield of Oklahoma to provide digital health and personal clinical engagement tools and services for members with coverage through BCBSOK. Registration is required to participate. Visit **www.BlueRewardsOK.com** to register and see what Healthy Actions earn rewards. If you do not have internet access, call Customer Service using the phone number on the back of your insurance card. Maximum annual rewards of $100 in gift cards. One reward per healthy action per year. Healthy action dates of service must be in the current Plan year. Healthy Actions that earn rewards are subject to change.

Step 6 Get the Most from Your Plan

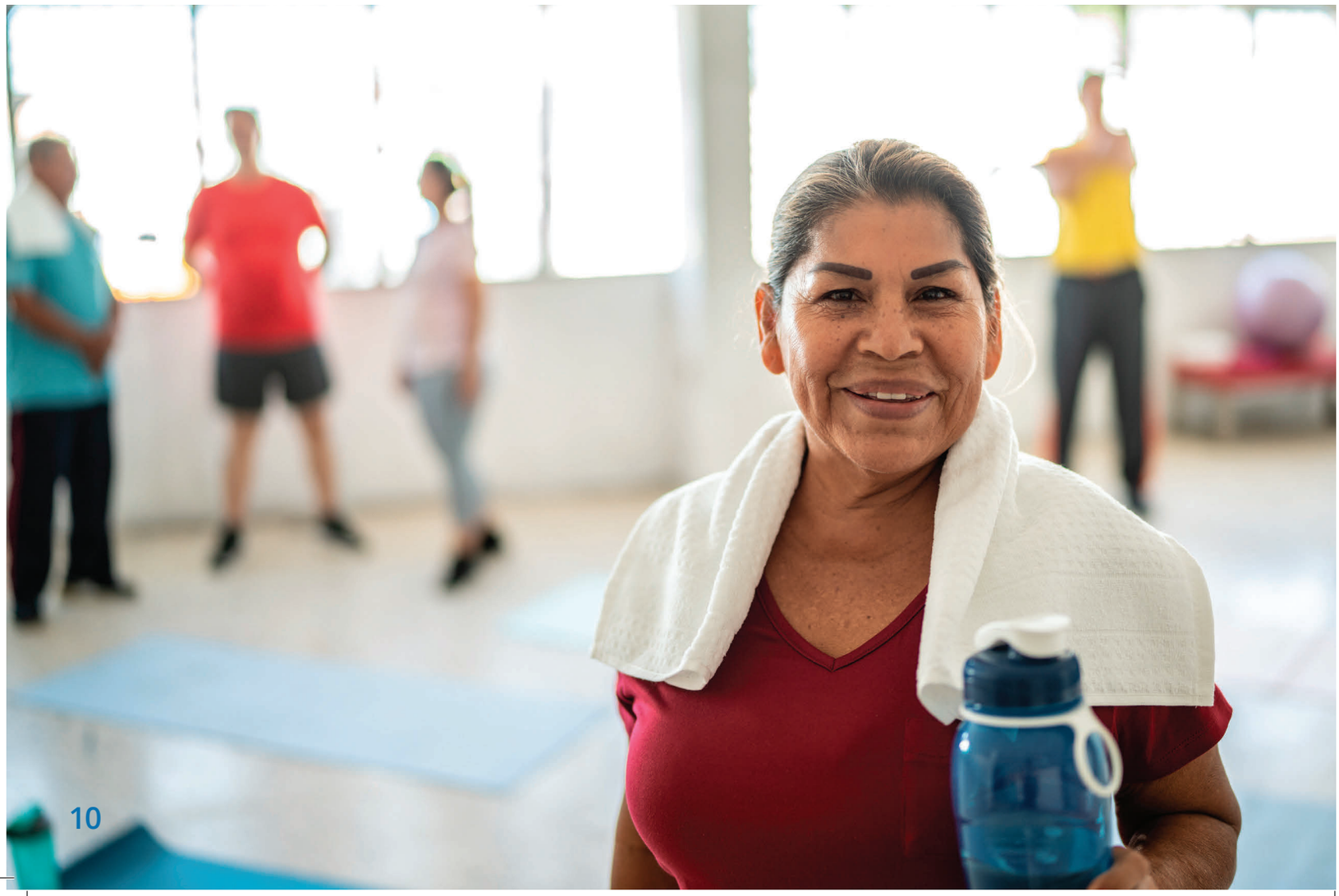
Notify your providers and pharmacy.

Show your new member ID card to your providers and pharmacy so they have the most up-to-date information. This can prevent your claim from being denied due to incorrect information.

Your Medical Benefits

BCBSOK-MAPD covers most commonly used services such as provider visits, inpatient and outpatient hospital services, emergency care, and prescription medicines. And it bundles these with wellness solutions for comprehensive health coverage. The plan manages claims and benefits, so you have only one call to make when you have questions. As a Medicare Advantage member, you get all the benefits covered by Original Medicare, and more. Read your EBI for details on coverage and member costs.

- Provider office visits
- Preventive services
- Emergency care
- Hospitalization
- Health screenings
- Diagnostic services
- Immunizations
- Rehabilitation
- Physical therapy
- Skilled nursing care



Your Formulary and Pharmacies

Your plan covers a broad range of prescription drugs. A formulary is a list of drugs your plan covers. You'll find the costs for your drugs listed in your EBI. Be sure to share the formulary with your providers and discuss any medications you are already taking. If you have questions, call us at the number listed on the back of your member ID card.

Drugs are placed in tiers.

The costs for drugs in each tier are different. Generally, drugs on lower-number tiers cost less. Tier 1 includes the drugs prescribed for common conditions. The drug list will tell you which tier a drug is in, and your EBI can tell you how much a drug costs.

Read the Formulary.

There are two ways to find medications: by medical condition and alphabetically. The formulary includes a table that shows more information about special programs, such as prior authorization, quantity limits or step therapy.

National Pharmacy Network

Our national pharmacy network includes thousands of locations where prescription copays may be lower than at an out-of-network pharmacy. All major national retail and grocery pharmacy chains participate in the network,* including:

Walgreens Walmart

Visit **www.bluememberok.com** to find a network pharmacy near you.

* Other pharmacies are also available in our network.

Important Reminder about What You Pay for Insulin and Vaccines

Insulin: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Vaccines: Your plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible.

Home Delivery and Specialty Pharmacy

Home Delivery

Choose convenience with our mail-order service. A 90-day supply of the medications you take regularly can be delivered directly to your home. This service offers:

- Three ways to order refills: online, by phone or through the mail.
- Up to a 90-day supply of medications at one time.
- A choice to get a text, email or phone call to let you know when your order is received, and your prescriptions are mailed.

You will need to set up an account using your member ID with one of these options:

AllianceRx Walgreens Pharmacy
Visit **www.alliancerxwp.com/home-delivery** or call **1-877-277-7895 TTY 711**.

Amazon Pharmacy
Visit **https://pharmacy.amazon.com** or call **1-855-393-4279 TTY 711**.
Available after January 1, 2024.

Express Scripts® Pharmacy
Visit **www.express-scripts.com/rx** or call **1-833-599-0729 TTY 711**.

Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross and Blue Shield of Oklahoma.

AllianceRx Walgreens Pharmacy, a central specialty and home delivery pharmacy, is contracted to provide mail pharmacy services to members of BCBSOK-MAPD. Prime Therapeutics LLC provides pharmacy benefit management services for Blue Cross and Blue Shield of Oklahoma and is owned by 18 Blue Cross and Blue Shield Plans, subsidiaries or affiliates of those plans.

Accredo is a specialty pharmacy that is contracted to provide services to members of BCBSOK. The relationship between Accredo and BCBSOK is that of independent contractors. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of BCBSOK. The relationship between Express Scripts® Pharmacy and BCBSOK is that of independent contractors. Express Scripts®

Specialty Pharmacy

Specialty medications are often prescribed to treat complex and/or chronic conditions. They have unique shipping or handling needs. You may be able to fill specialty prescriptions at certain retail pharmacies, if they stock the medication.

You can also use one of two specialty pharmacy options:

Out-of-Network Pharmacies

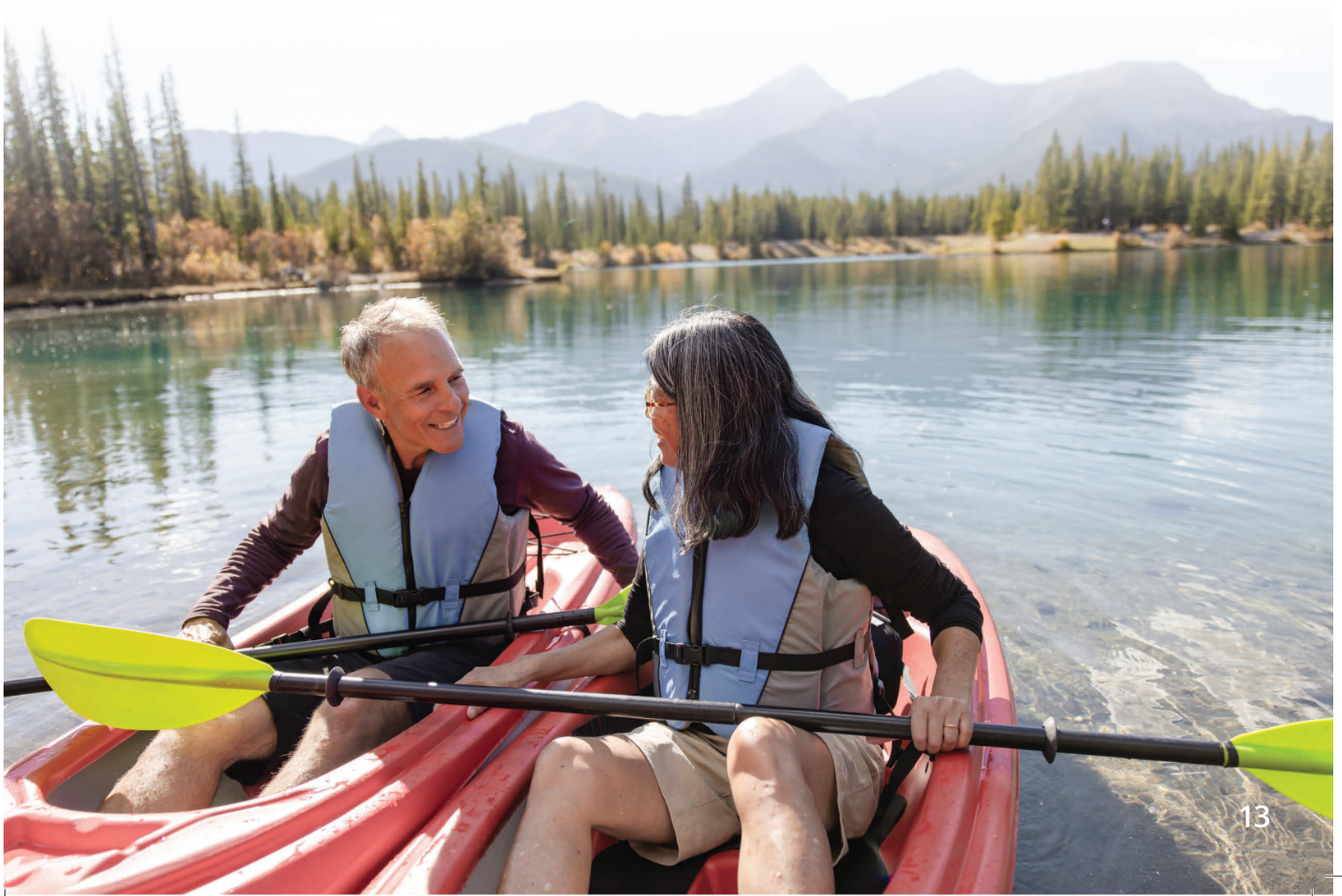
You can buy covered drugs from out-of-network pharmacies in an emergency or if you are traveling where there is no network pharmacy.

AllianceRx Walgreens Pharmacy

Visit **www.alliancerxwp.com/specialty-pharmacy** or call **1-800-533-7606 TTY 711** to get started.

Accredo®

Visit **www.accredo.com** or call **1-833-721-1619 TTY 711** to get started.



Step 7 Access Extra Health and Wellness Benefits and Member Rewards

BCBSOK-MAPD plans offer a number of benefits above and beyond standard insurance coverage.

Blue365®

Blue365 is just one more advantage of being a Blue Cross and Blue Shield of Oklahoma member. With this exclusive member program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or preauthorizations. Once you sign up, weekly 'featured deals' will be emailed to you. These deals offer special savings for a short period of time.

If you already have one, you can continue to use your Blue365 account. You do not need to re-enroll.

To learn more about Blue365, visit www.blue365deals.com/bcbsok.

24/7 Nurseline

Our nurses are available 24 hours a day, seven days a week, 365 days a year. They can help with health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care and more. You can also access an audio library of more than 1,000 health topics ranging from allergies to women's health. More than 600 topics are available in Spanish.

When should you call 24/7 Nurseline?

Call when you have questions about health problems, such as:

- Asthma, back pain, or chronic health problems
- Cuts or burns
- Dizziness or severe headache
- High fever
- Sore throat

You can access the 24/7 Nurseline at: 1-800-631-7023 TTY 711. You will find this number on the back of your member ID card.

Blue365 is a discount program only for BCBSOK members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Employees should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSOK does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSOK reserves the right to stop or change this program at any time without notice.

SilverSneakers® Fitness Program

SilverSneakers is a fitness program for seniors and includes unlimited access to thousands of fitness locations nationwide. Membership offers a welcoming community where you can have fitness fun with friends and meet new people.

SilverSneakers benefits include:

- Specialized fitness classes designed for people of all abilities and led by certified instructors
- FLEX classes like yoga and dance at parks, recreation centers and clubs
- Access to SilverSneakers LIVE virtual classes and hundreds of On-Demand classes at **SilverSneakers.com**

For more information, call Monday through Friday, 8 a.m. – 8 p.m. ET, 1-866-584-7389 TTY 711 or visit www.silversneakers.com/StartHere or email support@silversneakers.com.

Telehealth Services

Your retiree group Medicare Advantage plan covers Virtual Visits, provided by Blue Cross and Blue Shield of Oklahoma and powered by MDLIVE. With Virtual Visits, your appointment is with an independently contracted, board-certified MDLIVE doctor for minor, non-emergency medical or behavioral health conditions by phone, mobile app or online video anytime, anywhere, 24 hours a day, 7 days a week. Talk to a doctor immediately or schedule an appointment at a time that works best for you.

To activate your account, you can choose what is easiest for you:

- Go to **www.mdlive.com/bcbsok-medicare**
- Text BCBSOKMEDICARE to 635-483
- Download the MDLIVE app

To learn more about Virtual Visits benefits call 1-866-954-3583 (TTY 1-800-770-5531) or go to www.mdlive.com.

Join the Rewards Program

The Rewards Program gives you a healthy and easy way to earn up to $100 in gift cards annually from national retailers. You receive a gift card of your choice for completing Healthy Actions throughout the year.

Visiting your doctor at least once a year can help you catch small health problems before they become big ones. You can earn a gift card for getting qualified wellness visits. Because prevention is better than cure, you can earn $50 in gift cards just for completing your Annual Wellness Visit!

These Healthy Actions earn you rewards:

- Complete your Annual Wellness Visit or other qualified wellness visits
- Annual flu vaccine
- Colorectal cancer screening
- Bone density screening
- Mammogram
- Fall Risk Assessment
- Retinal eye exam
- Diabetic kidney and blood sugar testing

TAKE ACTION: Sign up to get started with the program.

1. Go to **www.BlueRewardsOK.com**. You will need your member ID card, date of birth and email address. After you register, we will send you an email letting you know that your account has been set up.
2. If you don't have an email address or have difficulty going online, you can call the number on the back of your member ID card to register.

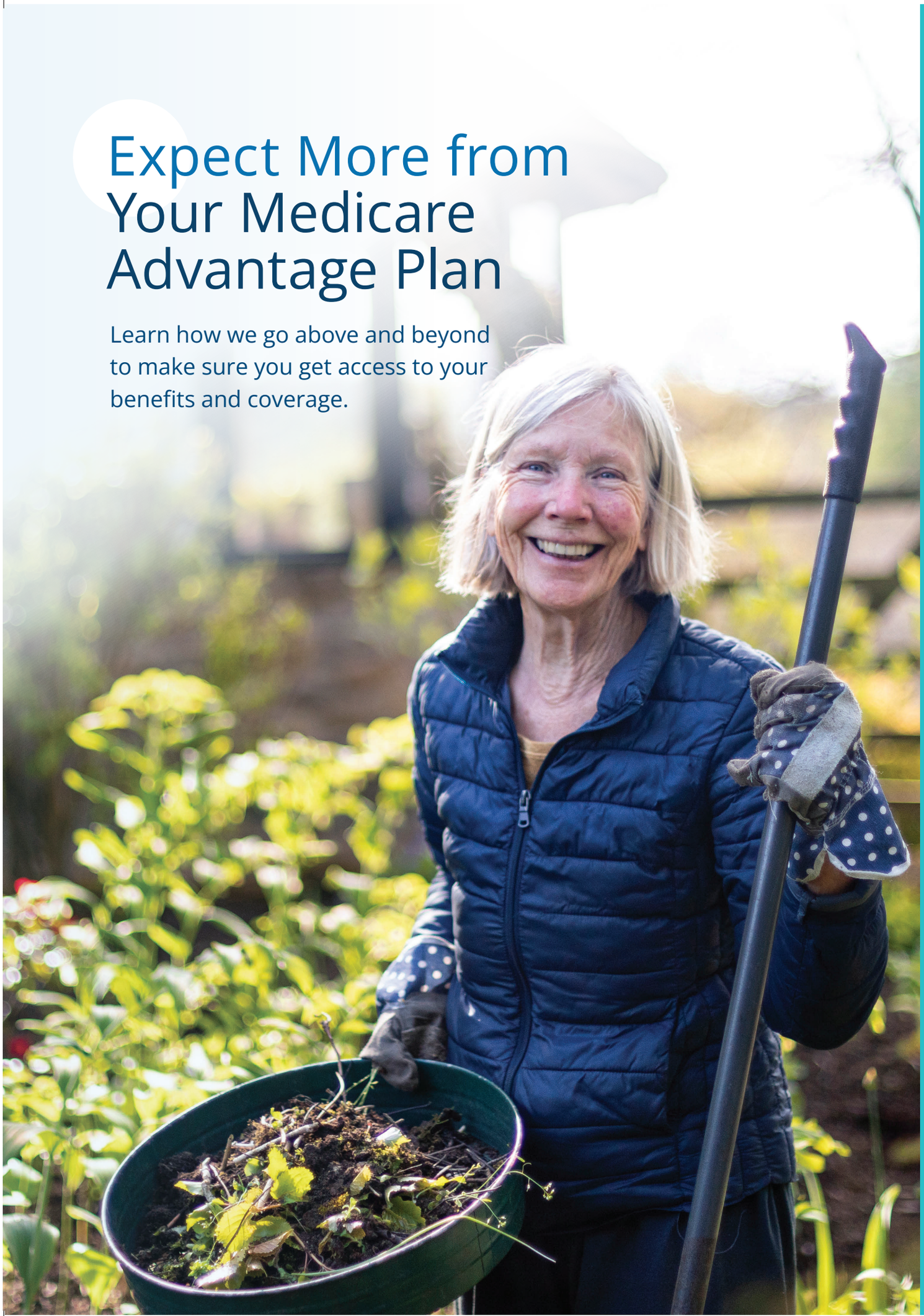
It may take up to 90 days for Healthy Actions to show as completed in the system. As soon as this happens, you can select your gift card from a list of national and local retailers.

Things to remember:

- Registration is required to participate.
- You can earn one reward per Healthy Action per year.
- Healthy Action dates of service must be in the current plan year.
- The maximum annual rewards is $100 in gift cards.
- Healthy Actions that earn rewards are subject to change.

Expect More from Your Medicare Advantage Plan

Learn how we go above and beyond to make sure you get access to your benefits and coverage.



Forms You May Need

You may need these forms during the year. All forms can be found on BAM at **www.bluememberok.com**.

- **Appointment of Representative**
  This form lets you choose someone to make decisions on your behalf. It also lets them get your health information such as Explanation of Benefits. This form may also be used to let the plan share your health information with a third party such as another health plan or provider. Having this completed form on file is vital for caregivers.
- **Prescription Mail Order**
  Be sure to take advantage of the mail-order program for eligible maintenance medicines. You'll enjoy the ease of home delivery and the chance to save money. When you have a new prescription, use the online form from the website of the home delivery pharmacy of your choice. See page 12 for more information.
- **Authorization to Disclose Protected Health Information (PHI)**
  Use this form to allow the plan to share your PHI with a person or entity you choose.
- **Coverage Determination**
  If the plan will not cover a prescription drug or medical service, you may ask for a coverage determination. Choose the form that matches your request.

Report Fraud

Medicare fraud costs billions of dollars each year.

Here are some ways you can help stop it:

- Keep your member ID card safe. Treat it like you would a debit or credit card.
- Make a copy of your member ID card and keep it in a safe place.
- If your member ID card is lost or stolen, call us right away.
- Be sure the pharmacy has your correct information.
- Look at your EOB carefully to be sure that you have been properly charged. If you think you may have been the victim of fraud, report it to our Fraud Hotline right away.

To report fraud,

call **1-800-543-0867 TTY 711,** 24 hours a day, 7 days a week

We'll Keep in Touch

Because we care about your well-being and want you to get the most from your Medicare plan, we'll be in touch with you throughout the year.

TAKE ACTION: Provide your email address!

Scan this **QR code** with your smartphone camera or go online at **www.bcbsok.com/preferences**.

We will contact you.

You can expect to hear from us occasionally to check in. We will be available to:

- Help you schedule an Annual Wellness Visit — a valuable part of your plan.
- Register you for the Rewards Program that can earn you up to $100 in gift cards.
- Answer any questions you have.

Annual Notice of Change (ANOC)

Near the end of the year, you'll receive an Annual Notice of Change from BCBSOK-MAPD. This notice outlines the premium/benefit changes (if any) for your plan. These changes will begin January 1 of the following calendar year. Review this document carefully.

Explanation of Benefits (EOB)

You'll receive a statement called Explanation of Benefits. How often you receive it depends on how often you fill your prescriptions or see your provider. This statement is not a bill. It simply details what you have paid and indicates the level of benefits you've used. Review these details to be sure they are correct. If you think there are errors, call Customer Service at the number on the back of your member ID card. If you think you are the victim of fraud, report it immediately.

Glossary of Terms

We have described some commonly used terms to help you understand more about your plan. Refer to your benefit plan materials if you have questions.

Allowed Amount
The maximum amount a plan will pay for a covered health care service. If you are charged more than the plan's allowed amount, you may have to pay the difference.

Amount Billed
The amount your provider billed for the service(s) rendered.

Coinsurance
An amount you pay after any deductibles. This is usually a percentage of the cost. For example, if the plan pays 80% of the allowed amount, then 20% would be your coinsurance.

Copayment (Copay)
Your share of the cost for each provider visit, service or prescription drug. This is usually a set dollar amount (for example: $10).

Deductible
An amount, if any, you pay before a plan begins to share the cost of covered drugs and services.

Formulary (Drug List)
A list of drugs covered by your plan.

Non-Participating Provider
An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit
Once you pay this amount in deductibles, copays and coinsurance for covered services, the plan pays 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider
An in-network or out-of-network provider who accepts Medicare and the agreed-upon rates for services.

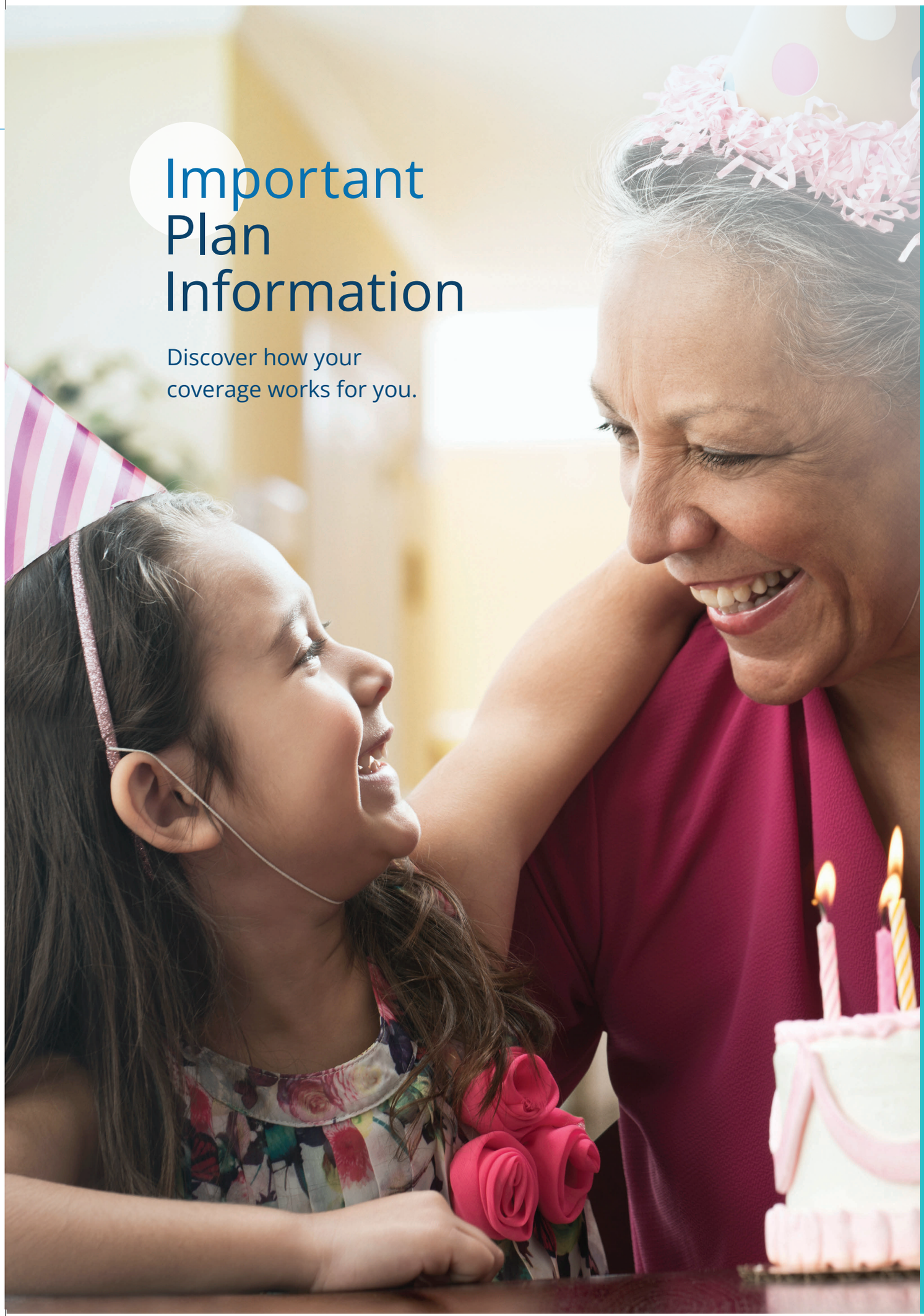
Pharmacy Network
Pharmacies that contract with a Part D plan to fill prescriptions for its members. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Prior Authorization (PA)*
Some drugs may need to be approved by the plan before they are covered.

Quantity Limits (QL)*
A limit to how much of a medication will be covered in a certain time period. Limits may be applied on select drugs.

Step Therapy*
You may need to try less expensive options before 'stepping up' to certain high-cost drugs.

*Your formulary will indicate if a drug is subject to one of these special programs. Look for the abbreviation for the program to the right of the drug name and tier.



Important Plan Information

Discover how your coverage works for you.

BlueCross BlueShield of Oklahoma

Important Information
ABOUT YOUR PLAN

You can find the most current information about your plan benefits when you visit Blue Access for Members℠ (BAM℠) at **www.bluememberok.com**.

If you don't already have a BAM account, you can create one the first time you use the service. You can also download the mobile app by texting BCBSOKAPP to 33633. Be sure to have your member ID card handy when setting up your account.

Here's what you'll find:

- Annual Notice of Changes (if a returning member)
- Drug Formulary Lists
- Evidence of Coverage
- In-Network Pharmacies
- Provider Finder
- Summary of Benefits

You may also request that printed copies of these items be mailed to you by calling Customer Service at the number on the back of your member ID card. Our Customer Service representatives are available to help if you have any questions.

Thank you for being a Blue Cross Group Medicare Advantage℠ member. We look forward to serving you.

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BlueCross BlueShield of Oklahoma

State of Oklahoma

Blue Cross Group Medicare Advantage Open Access (PPO)[SM]

Evidence of Coverage Benefits Insert

January 1 – December 31, 2024

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2024 Evidence of Coverage Benefits Insert

Table of Contents

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

Section 1.2 What is your plan deductible?

This plan does not have a deductible for medical services.

Section 1.3 What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network and out-of-network medical services that are covered by our plan. The most you will have to pay out-of-pocket for covered in-network and out-of-network services is listed below.

Your combined maximum out-of-pocket amount is $0. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount for medical services. In addition, amounts you pay for some services, such as supplemental benefits and non-Medicare Part D drugs do not count toward your combined maximum out-of-pocket amount. If you have paid $0 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

See also Section 2.1 of Chapter 4 in the *Evidence of Coverage* booklet for more information.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-network** $0 copay for Medicare-covered services.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy.	**In-network** $0 copay for each Medicare-covered visit. **Out-of-network** $0 copay for each Medicare-covered visit.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. ***Authorization rules may apply*** Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/ clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Services that are covered for you	What you must pay when you get these services
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. ***Authorization rules may apply***	**In-network** $0 copay for each one-way Medicare-covered ground transportation service. $0 copay for each one-way Medicare-covered air transportation service. **Out-of-network** $0 copay for each one-way Medicare-covered ground transportation service. $0 copay for each one-way Medicare-covered air transportation service.
Annual physical exam The routine physical examination is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, hands on examination, anticipatory guidance/ risk factor reduction interventions. ***Authorization rules may apply***	**In-network** $0 copay for an annual routine physical exam. **Out-of-network** $0 copay for an annual routine physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-network** $0 copay for Medicare-covered services.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-network** $0 copay for Medicare-covered services.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered intensive cardiac rehabilitation services. **Out-of-network** $0 copay for Medicare-covered cardiac rehabilitation services. $0 copay for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services (continued)	
	intensive cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-network** $0 copay for Medicare-covered services.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-network** $0 copay for Medicare-covered services.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months	**In-network** There is no coinsurance, copayment, or deductible for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening (continued) • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months ***Authorization rules may apply***	preventive Pap and pelvic exams. **Out-of-network** $0 copay for Medicare-covered services.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	**In-network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. $0 copay for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. ***Authorization rules may apply***	**Out-of-network** $0 copay for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered barium enema.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-network** $0 copay for Medicare-covered services.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. **Out-of-network** $0 copay for Medicare-covered services.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**In-network** 0% of the total cost for preferred test strips 0% of the total cost for non-preferred test strips 0% of the total cost for all other diabetes supplies

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies (continued)	
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. ***Authorization rules may apply***	0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services. **Out-of-network** 0% of the total cost for preferred test strips 0% of the total cost for non-preferred test strips 0% of the total cost for all other diabetes supplies 0% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of the *Evidence of Coverage* document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider	**In-network** $0 copay for Medicare-covered durable medical equipment and supplies.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (continued)	
for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9 in the *Evidence of Coverage* booklet, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.) ***Authorization rules may apply***	**Out-of-network** $0 copay for Medicare-covered durable medical equipment and supplies. **Authorization required if cost is greater than $2,500**
Emergency care	
Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	**In-network and Out-of-network** $0 copay for Medicare-covered emergency room visits. Cost share is waived if admitted within three days for the same condition. **Worldwide Coverage** $0 copay for Worldwide emergency services. No annual limit.

Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	
Worldwide emergency/urgent care services are covered.	Cost share is waived if admitted within three days for the same condition.
Health and wellness education programs	
SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. **1.** Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. **2.** Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of	$0 copay for this wellness program.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs (continued) Tivity Health, Inc.© 2020 Tivity Health, Inc. All rights reserved.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. We cover: • Medicare-covered services ***Authorization rules may apply***	***Medicare-Covered Services:*** **In-network** $0 copay for each Medicare-covered hearing exam. **Out-of-network** $0 copay for each Medicare-covered hearing exam.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-network** $0 copay for Medicare-covered services.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Home health agency care (continued) • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies ***Authorization rules may apply***	
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered professional services. $0 copay for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs. **Out-of-network** $0 copay for Medicare-covered professional services. $0 copay for Medicare-covered supplies. 0% of the total cost for Medicare-covered home infusion drugs.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you	When you enroll in a Medicare-certified hospice

Services that are covered for you	What you must pay when you get these services
Hospice care (continued)	
a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services are the same whether or not you use a network provider. You may seek care from any provider that accepts Medicare. <u>For services that are covered by Blue Cross Group Medicare Advantage Open Access (PPO) but are not covered by Medicare Part A or B:</u> Blue Cross Group	program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Blue Cross Group Medicare Advantage Open Access (PPO).

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) Medicare Advantage Open Access (PPO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. <u>For drugs that may be covered by the plan's Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see the *Evidence of Coverage* booklet Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. ***Authorization rules may apply***	**<u>In-network</u>** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. **<u>Out-of-network</u>** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care 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. Plan covers an unlimited number of days per benefit period. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-network** $0 copay per stay **Out-of-network** $0 copay per stay If you get 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.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) to accept the Original Medicare rate. If Blue Cross Group Medicare Advantage Open Access (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***	

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. ***Authorization rules may apply***	**In-network** $0 copay per stay **Out-of-network** $0 copay per stay
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-network** $0 copay for Medicare-covered services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases For a list of Part B Drugs that may be subject to Step Therapy, contact Customer Service. We also cover some vaccines under our Part B and Part D prescription drug benefit.	Part B drugs ***may*** be subject to step therapy requirements. You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible. **In-network** 0% of the total cost for Medicare-covered chemo drugs. 0% of the total cost for other Medicare Part B drugs. **Out-of-network** 0% of the total cost for Medicare-covered chemo drugs. 0% of the total cost for other Medicare Part B drugs. ***Prior authorization and/or step therapy may be required***

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs (continued) Chapter 5 in the *Evidence of Coverage* booklet explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-network** $0 copay for Medicare-covered services.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests ***Authorization rules may apply***	**In-network** **Medicare-covered outpatient X-ray services:** $0 copay **Medicare-covered outpatient therapeutic radiology services** (such as radiation treatment for cancer): $0 copay **Medicare-covered medical supplies:** $0 copay **Medicare-covered outpatient lab services:** $0 copay **Medicare-covered outpatient blood services:** $0 copay **Medicare-covered diagnostic procedures/ tests:** $0 copay **Medicare-covered outpatient diagnostic radiology services** (such as MRIs and CT scans): $0 copay

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	
	<u>Out-of-network</u> **Medicare-covered outpatient X-ray services:** $0 copay **Medicare-covered outpatient therapeutic radiology services** (such as radiation treatment for cancer): $0 copay **Medicare-covered medical supplies:** $0 copay **Medicare-covered outpatient lab services:** $0 copay **Medicare-covered outpatient blood services:** $0 copay **Medicare-covered diagnostic procedures/ tests:** $0 copay **Medicare-covered outpatient diagnostic**

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	**radiology services** (such as MRIs and CT scans): $0 copay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered observation services. **Out-of-network** $0 copay for Medicare-covered observation services.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services. **Out-of-network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care	
Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered individual visits with a psychiatrist. $0 copay for each virtual visit with a psychiatrist through MDLive. $0 copay for Medicare-covered group visits with a psychiatrist. $0 copay for Medicare-covered individual visits with a mental health specialist. $0 copay for each virtual visit with a mental health specialist through MDLive. $0 copay for Medicare-covered group visits with a mental health specialist. **Out-of-network** $0 copay for Medicare-covered individual visits with a psychiatrist. $0 copay for Medicare-covered group visits with a psychiatrist. $0 copay for Medicare-covered individual visits with a mental health specialist.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care (continued)	
	$0 copay for Medicare-covered group visits with a mental health specialist.
Outpatient rehabilitation services	
Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered occupational therapy services. $0 copay for Medicare-covered physical, language and speech therapy services. **Out-of-network** $0 copay for Medicare-covered occupational therapy services. $0 copay for Medicare-covered physical, language and speech therapy services.
Outpatient substance abuse services	
Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered individual substance abuse treatment. $0 copay for Medicare-covered group substance abuse treatment.

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services (continued)	
	$0 copay for Medicare-covered partial hospitalization services. **<u>Out-of-network</u>** $0 copay for Medicare-covered individual substance abuse treatment. $0 copay for Medicare-covered group substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. ***Authorization rules may apply***	**<u>In-network</u>** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered observation services. **<u>Out-of-network</u>** $0 copay for Medicare-covered outpatient hospital services.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (continued)	
	$0 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered observation services.
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered partial hospitalization services. **Out-of-network** $0 copay for Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist	**In-network** $0 copay for Medicare-covered primary care physician services. $0 copay for Medicare-covered physician specialist services.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued)	
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ◦ You're not a new patient **and** ◦ The evaluation isn't related to an office visit in the past 7 days **and**	$0 copay for Medicare-covered services provided by other health care professionals such as nurse practitioners, physician assistants, etc. **Out-of-network** $0 copay for Medicare-covered primary care physician services. $0 copay for Medicare-covered physician specialist services. $0 copay for Medicare-covered services provided by other health care professionals such as nurse practitioners, physician assistants, etc.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Supplemental telehealth for urgent care and behavioral services available through MDLive. Please refer to Telehealth section for additional information. ***Authorization rules may apply***	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam. **Out-of-network** $0 copay for Medicare-covered services. $0 copay for an annual Medicare-covered digital rectal exam.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered prosthetics. $0 copay for Medicare-covered medical supplies. **Out-of-network** $0 copay for Medicare-covered prosthetics. $0 copay for Medicare-covered medical supplies. **Authorization required if cost is greater than $2,500**

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services	
Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. ***Authorization rules may apply***	**In-network** $0 copay for Medicare-covered services. **Out-of-network** $0 copay for Medicare-covered services.
Rewards Program	
Rewards Program for Healthy Activities You can earn rewards for completing selected screenings, managing chronic conditions, or seeing your physician for a physical. Members can potentially receive rewards for completing eligible health activities during the calendar year (January 1 - December 31). The amount of the reward is up to a maximum of $100 annually and will be triggered by submission of a claim. Most Healthy Action completions reward members $25 in the form of a gift card. The Annual Wellness Visit will reward members $50 upon completion. These rewards can be redeemed for a variety of gift cards that can be used at select pharmacies or national retailers. Members can opt to obtain a gift card for the completion of each individually completed healthy activity or they can opt to pool their reward amounts for numerous completed healthy activities. A maximum of one payment for each specific healthy activity per year will be rewarded until you reach the $100 maximum. ***Authorization rules may apply***	Earn up to $100 annually for completing healthy activities* such as the examples below: • Welcome to Medicare/Annual Physical or Qualified Wellness Visits • Annual Flu Vaccine • Colorectal Screening • Retinal Exam • Mammogram Additional healthy activities may be identified and provided to members after the beginning of the plan year via mail, email, or through the member portal. *This list is subject to change. The Rewards Program offers the above healthy activities for all members as well as additional healthy activities based on your unique needs.

Services that are covered for you	What you must pay when you get these services
Rewards Program (continued)	
	To register and determine the current list of healthy activities, go to www.BlueRewardsOK.com. You will need your member ID card, date of birth and email address to register online if you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account. **REGISTRATION IS REQUIRED**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. **Out-of-network** $0 copay for Medicare-covered services.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued)	
sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. ***Authorization rules may apply***	**Out-of-network** $0 copay for Medicare-covered services
Services to treat kidney disease	
Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, of the *Evidence of Coverage* booklet, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about	**In-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education. **Out-of-network** $0 copay for Medicare-covered dialysis services. $0 copay for Medicare-covered kidney disease education.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease (continued) coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs. ***Authorization rules may apply***	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of the Evidence of Coverage. Skilled nursing facilities are sometimes called SNFs.) Plan covers 100 days per benefit period. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a	**In-network** $0 copay per day for days 1-20 $0 copay per day for days 21-100. **Out-of-network** $0 copay per day for days 1-20 $0 copay per day for days 21-100.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (continued) facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital ***Authorization rules may apply***	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. ***Authorization rules may apply***	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-network** $0 copay for Medicare-covered services.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	**In-network** $0 copay for Medicare-covered supervised exercise therapy. **Out-of-network** $0 copay for Medicare-covered

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) (continued) • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. ***Authorization rules may apply***	supervised exercise therapy.
Supplemental telehealth services Covered services include: • Certain telehealth services, including: urgent care and behavioral health services. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ This telehealth service is offered through MDLive. Members will need to complete registration and be directed to complete a medical questionnaire upon first visit to the MDLive portal. Please contact MDLive at 1-888-680-8646 or visit the MDLive website at www.mdlive.com. Access to telehealth service can be completed through computer, tablet, smartphone, traditional phone and can include web-based video.	**In-network** $0 copay for urgent care; $0 copay for Outpatient Mental Health; $0 copay for Outpatient Mental Health Psychiatric visit through MDLive. **Out-of-network** Not Covered

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition, and is not a medical emergency, or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. In these examples, your plan will cover the urgently needed services from a provider out-of-network. **Worldwide emergency/urgent care services are covered.**	**In-network** $0 copay for Medicare-covered services. $0 copay for each virtual visit through MDLive. **Out-of-network** $0 copay for Medicare-covered services. **Worldwide coverage** $0 copay for each visit.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/ contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year	***Medicare-Covered Services:*** **In-network** $0 copay for Medicare-covered services. $0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery. **Out-of-network** $0 copay for Medicare-covered services.

Services that are covered for you	What you must pay when you get these services
Vision care (continued)	
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) ***Authorization rules may apply***	$0 copay for an annual glaucoma screening. $0 copay for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery.
Welcome to Medicare preventive visit	
The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	**In-network** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. **Out-of-network** $0 copay for Medicare-covered services.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, are not covered by this plan. If a service is excluded, it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself, except under the specific conditions listed below. Even if you receive the excluded

services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

The only exception we will pay is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in the *Evidence of Coverage* document.)

Services not covered by Medicare	**Not covered under any condition**	**Covered only under specific conditions**
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 of the Evidence of Coverage for more information on clinical research studies.)
Private room in a hospital		• Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Full-time nursing care in your home.	**Not covered under any condition**	
*Custodial care. (Care that helps with activities of daily living that does not require professional skills or training. e.g. bathing and dressing.)	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition**	
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as fillings or dentures.	**Not covered under any condition**	
Non-routine dental care		• **Dental care required to treat illness or injury may be covered as inpatient or outpatient care.**
Routine chiropractic care		• **Manual manipulation of the spine to correct a subluxation is covered.**
Routine foot care		• Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Radial keratotomy, LASIK surgery, and other low vision aids.	**Not covered under any condition**	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Acupuncture		• Available for people with chronic low back pain under certain circumstances.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Chapter 6. What you pay for your Part D prescription drugs

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Blue Cross Group Medicare Advantage Open Access (PPO) members?

There are four "drug payment stages" for your prescription drug coverage under Blue Cross Group Medicare Advantage Open Access (PPO). How much you pay depends

on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

SECTION 4 During the Deductible Stage, you pay the full cost of your Part D drugs

There is no deductible for Blue Cross Group Medicare Advantage Open Access (PPO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Retail (standard and preferred) cost sharing (in-network) (up to a 30-day supply)	Mail-order (standard and preferred) cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see the *Evidence of Coverage* Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Standard:** $12 **Preferred:** $5	**Standard:** $12 **Preferred:** $5	$12	$12
Cost-Sharing Tier 2 (Generic)	**Standard:** $22 **Preferred:** $15	**Standard:** $22 **Preferred:** $15	$22	$22
Cost-Sharing Tier 3 (Preferred Brand)	**Standard:** $47 **Preferred:** $40	**Standard:** $47 **Preferred:** $40	$47	$47
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Standard:** $97 **Preferred:** $90	**Standard:** $97 **Preferred:** $90	$97	$97
Cost-Sharing Tier 5 (Specialty)	**Standard:** 33% **Preferred:** 33%	**Standard:** 33% **Preferred:** 33%	33%	33%

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Retail (standard and preferred) cost sharing (in-network) (up to a 90-day supply)	Mail-order (standard and preferred) cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Standard:** $36 **Preferred:** $15	**Standard:** $36 **Preferred:** $15
Cost-Sharing Tier 2 (Generic)	**Standard:** $66 **Preferred:** $45	**Standard:** $66 **Preferred:** $45
Cost-Sharing Tier 3 (Preferred Brand)	**Standard:** $141 **Preferred:** $120	**Standard:** $141 **Preferred:** $120
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Standard:** $291 **Preferred:** $270	**Standard:** $291 **Preferred:** $270
Cost-Sharing Tier 5 (Specialty)	**Standard:** 33% **Preferred:** 33%	**Standard:** 33% **Preferred:** 33%

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 of the EOC on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

The tables below show what you pay for prescription drugs during the Coverage Gap Stage.

Coverage Gap Stage Tier	**Retail (standard and preferred) cost sharing (in-network)** (30-day supply)	**Retail (standard and preferred) cost sharing (in-network)** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Standard:** $12 **Preferred:** $5	**Standard:** $36 **Preferred:** $15
Cost-Sharing Tier 2 (Generic)	**Standard:** $22 **Preferred:** $15	**Standard:** $66 **Preferred:** $45
Cost-Sharing Tier 3 (Preferred Brand)	**Standard:** $47 **Preferred:** $40	**Standard:** $141 **Preferred:** $120
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Standard:** $97 **Preferred:** $90	**Standard:** $291 **Preferred:** $270
Cost-Sharing Tier 5 (Specialty)	**Standard:** 15% **Preferred:** 15%	**Standard:** 15% **Preferred:** 15%

Coverage Gap Stage Tier	**Mail-order (standard and preferred) cost sharing** (30-day supply)	**Mail-order (standard and preferred) cost sharing** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	**Standard:** $12 **Preferred:** $5	**Standard:** $36 **Preferred:** $15
Cost-Sharing Tier 2 (Generic)	**Standard:** $22 **Preferred:** $15	**Standard:** $66 **Preferred:** $45
Cost-Sharing Tier 3 (Preferred Brand)	**Standard:** $47 **Preferred:** $40	**Standard:** $141 **Preferred:** $120
Cost-Sharing Tier 4 (Non-Preferred Drug)	**Standard:** $97 **Preferred:** $90	**Standard:** $291 **Preferred:** $270

Coverage Gap Stage **Tier**	**Mail-order (standard and preferred) cost sharing** (30-day supply)	**Mail-order (standard and preferred) cost sharing** (90-day supply)
Cost-Sharing Tier 5 (Specialty)	**Standard:** 15% **Preferred:** 15%	**Standard:** 15% **Preferred:** 15%

Medicare has rules about what counts and what does not count toward your out-of-pocket costs (Section 1.3).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's "Drug List" or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)
- You will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.
- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in the Evidence of Coverage.
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in the Evidence of Coverage.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

HMO and PPO plans provided by Blue Cross and Blue Shield of Oklahoma, which refers to GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC and BlueLincs are Independent Licensee of the Blue Cross and Blue Shield Association. HCSC and BlueLincs are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and BlueLincs' plans depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross Group Medicare Advantage Open Access (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage Benefits Insert for more information, including the cost sharing that applies to out-of-network services.

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BlueCross BlueShield of Oklahoma

Blue Cross and Blue Shield of Oklahoma complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Oklahoma does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Oklahoma:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Oklahoma has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, a Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-299-1008** (TTY/TDD: **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-299-1008** (TTY/TDD: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-877-299-1008** (TTY/TDD: **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-877-299-1008** (TTY/TDD: **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-299-1008** (TTY/TDD: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-299-1008** (TTY/TDD: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-299-1008** (TTY/TDD: **711**). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phi.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-299-1008** (TTY/TDD: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-299-1008** (TTY/TDD: **711**). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-299-1008** (TTY/TDD: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: سيقوم شخص ما يتحدث العربية إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول **1-877-299-1008** (TTY/TDD: **711**). بمساعدتك. هذه خدمة مجانية على مترجم فوري، ليس عليك سوى الاتصال بنا على

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-299-1008** (TTY/TDD: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-299-1008** (TTY/TDD: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-299-1008** (TTY/TDD: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-299-1008** (TTY/TDD: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-299-1008** (TTY/TDD: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-877-299-1008** (TTY/TDD: **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2024 Medicare Star Ratings

Blue Cross Group Medicare Advantage - H0107

For 2024, Blue Cross Group Medicare Advantage- **H0107 received the following Star Ratings from Medicare:**

Overall Star Rating:

Health Services Rating: ★★★½☆

Drug Services Rating: ★★★½☆

★★★☆☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 877-583-8129 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time and alternate technologies (for example, voicemail) will be used on weekends and holidays.Current members please call 877-299-1008 (toll-free) or 711 (TTY).

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HMO and PPO plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HMO plans available for employer/union groups only. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plan depends on contract renewal.

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Contact Information

Have questions or concerns? Call us first. We can help!

Contact us before calling Medicare. BCBSOK-MAPD is your Medicare plan. You should call us with all your questions. We will let you know if your question can only be answered by Medicare.

Call

Call the Customer Service number listed on the back of your member ID card. We are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Web

Blue Access for Members

Search for providers and get information about your plan, claim status and benefits.
www.bluememberok.com

Rewards Program

www.bluerewardsok.com

Connect Community

Connect is a fun way to interact with other members through our online blog-style format. Learn about health and wellness, benefits and coverage, how health insurance works and much more.

Connect at **http://connect.bcbsok.com/medicare**.

This information is not a complete description of benefits. The formulary and pharmacy network may change at any time. You will receive notice when necessary.

BCBSOK makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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