Blue Cross Group Medicare Advantage Open Access (PPO)℠

The advantage is yours.

Look inside for:

- Details about your BCBSOK-MAPD℠ plan
- Getting started
- What to expect

live your
Blue life℠

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Medicare coverage made easy

BCBSOK-MAPD Open Access (PPO) is your all-in-one plan.

Your benefit administrator offers BCBSOK-MAPD for your retiree Medicare coverage. It bundles Medicare Parts A and B plus extra health and wellness benefits not offered by Original Medicare. It covers most commonly used services such as provider visits, inpatient hospital and outpatient services, emergency care and prescription medicines.

Here's how your Open Access PPO plan works.

Your Providers

With an Open Access PPO plan, you can see any provider that accepts Medicare. That's about 98% of providers nationwide. The provider will need to submit claims either to Blue Cross and Blue Shield of Oklahoma (BCBSOK) or to their local Blue Cross and Blue Shield (BCBS) plan. Your benefits are the same if you use a provider that is in the BCBS network or not.

If your providers say they are not in the network, show them the 'Your Providers, Your Personal Network' flyer included in this kit. It explains the plan and how they can submit your claims.

Please note: Even providers that accept Medicare can decide which patients they want to see, except in an emergency. We recommend that you confirm with providers that they will accept your Open Access PPO plan.

Some high-cost medical services that have more cost-effective alternatives may need prior authorization from the plan before your provider can proceed.*

Find providers at **www.bcbsok.com/retiree-medicare-tools**.

*Non-contracted providers are not required to adhere to our prior authorization requirements; however, the member and/or provider may elect to request a medical necessity determination in advance as services should meet medical necessity criteria to be covered.

Your Prescription Drug Coverage

Copay and Deductible

You may have a copay or coinsurance for your prescriptions. Some plans have a deductible you will need to meet before benefits start. After spending a government-set amount on medications, you may reach or even go past the coverage gap in a year. Copays and coinsurances can change during these stages. Review the Summary of Benefits to understand deductibles and the coverage gap in your plan.

Important Message 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 any required deductible.

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

List of Covered Drugs (Formulary)

Within the formulary, you will see that prescription drugs are placed into tiers. The costs for drugs in each tier are generally different. Tier 1 includes the drugs prescribed for common conditions.

Pharmacies in the Neighborhood and across the Nation

Our national pharmacy network includes thousands of locations. All major national retail and grocery pharmacy chains participate in the network, including:

Walgreens Walmart

Other pharmacies are available in our network.

Before you enroll, you can search for your medicines online at www.myprime.com.*

Select 'Medicines,' then:

- **'Find a Medicine,' followed by**
- **'Continue without sign in.'**

Under 'Select Your Health Plan':

- **Select BCBS Oklahoma.**
- **Answer 'Yes.'**
- **Select Blue Cross Group Medicare Advantage (PPO)℠.**
- **Click 'Continue.'**

Type your medicine and dosage.

- **Review the drug tier and requirements.**
- **Refer to the Summary of Benefits for your cost.**

* MyPrime.com is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, a separate company providing pharmacy benefit management services for your plan.

Extra health and wellness benefits complete your coverage.

Wellness Solutions

Track your health and keep learning with our wellness and education tools. You can set and monitor progress toward your health care goals. You can also learn about:

- Diabetes self-care.
- Managing blood pressure.
- Eating well and healthy weight.
- Stopping tobacco use.
- Stress management and mental health.
- Safety tips.

Fitness Designed for You

The SilverSneakers®†† Fitness Program is included in your plan. It helps you achieve your health and fitness goals with access to more than 15,000 fitness locations and online classes led by certified instructors.

Virtual Visits

Virtual Visits allow you to consult an independently contracted, board-certified doctor or therapist for non-emergency situations by phone, mobile app or online video anytime, anywhere. Speak to a doctor or schedule an appointment at a time that works best for you. Your current provider may offer virtual visits.

24/7 Nurseline

Your call is taken by a registered nurse who can help if you are sick or hurt and not sure what to do.

These extra health and wellness benefits are part of your retiree group Medicare Advantage plan. Please read the Summary of Benefits for coverage details.

† 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.

†† Classes and amenities vary by location.

What happens after you enroll?

1. Medicare Approval

You must be a retiree enrolled in Medicare Part A and Part B to be eligible for this plan. Medicare must approve your enrollment before you are officially a member. This generally takes about 10 business days.

2. Acknowledgment and Confirmation Letters

We'll let you know the status of your enrollment. Within 10–14 days of receiving your enrollment, we'll send you an acknowledgment letter. It explains that we've received your information and are waiting for Medicare to approve your eligibility. After Medicare approves, we'll send you a confirmation letter followed by your member ID card.

3. Member ID Card

Always show your BCBSOK ID card when you visit a provider or pharmacy. Information on the ID card helps the provider file your claim with us.

Your card will have this information:

- **Your name**
- **The name of your retiree group Medicare plan**
- **Member ID number**
  This number is unique to you.
- **Plan number**
  This number is used by the plan only.
- **Copays**
  These are the fixed amounts you may have to pay when you visit a provider.
- **Customer service phone number**
- **Our website**

If your ID card hasn't come in the mail by your effective date, you can still use your benefits. Just show your confirmation letter as proof of insurance.

4. Welcome Kit

Your Welcome Kit usually arrives after your member ID card and contains a Welcome Guide, Formulary, Evidence of Coverage Benefit Insert and information to help you get the most from your plan.

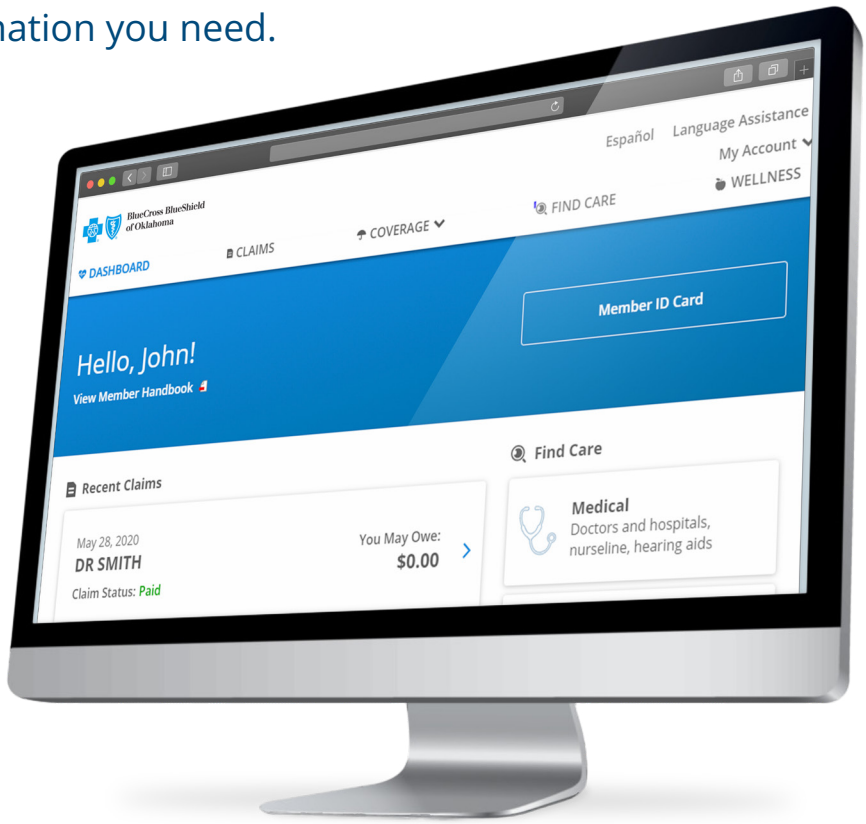
Staying Connected

Once you are a member, your plan becomes your partner in health. We will reach out during the year with helpful reminders and health tips. If you have a special medical condition, you may receive personalized communication from our medical professionals. They can help you manage your health and find resources just for you. Feel free to reach out to customer service with questions, or if you are unsure about any communications you get about your plan. And please tell us if you have any special needs we should know about.

Blue Access for Members℠

Register for Blue Access for Members (BAM℠) at www.bluememberok.com.

BAM is a secure website designed to give you quick, easy access to the health information you need. Bookmark it on your computer or download the easy-to-use mobile app.



You can:

- Search for providers and pharmacies.
- See your prescription history.
- View claims status and up to 18 months of activity.
- Request an ID card or print a temporary ID.
- and much more.

It's Easy to Get Started!

Go to **www.bluememberok.com** or grab your smartphone and your member ID card and text† BCBSOKAPP to 33633 so you can use BAM while you're on the go.

† Message and data rates may apply.

Blue Cross and Blue Shield of Oklahoma is honored to be entrusted with your care.

We are committed to providing you with outstanding service, medical expertise and convenience.

Let's get started.

1. You must be a retiree enrolled in Medicare Part A and Part B. You must continue to pay any required Part A or Part B premiums. These are usually deducted from your Social Security benefit. If you haven't signed up yet, contact your local Social Security office or go to **www.ssa.gov** to enroll online.

2. Review this brochure and the enclosed Summary of Benefits for details about your plan.

3. **It's time to enroll!** Follow the enrollment instructions provided by your benefit administrator.

4. Watch the mailbox for your enrollment acknowledgment and confirmation letters, followed by your new member ID card and your Welcome Kit.

Frequently Asked Questions about Medicare and Open Access Medicare Advantage plans.

Q. What is Medicare?

A. Medicare is the government health care program designed for people ages 65 and over. Most U.S. citizens earn the right to enroll in Medicare by working and paying their taxes for a minimum of 10 years. Under certain circumstances, people under 65 may be eligible for Medicare.

There are four parts of Medicare related to specific services:

Part A — Hospital coverage

Part B — Medical coverage

Part C — Medicare Advantage Plans (private insurers like BCBSOK that contract with the government to provide Medicare coverage through a variety of insurance products).

Part D — Prescription drug coverage

IMPORTANT: To participate in an employer-sponsored Medicare plan, you will need to enroll in both Parts A and B. If you do not enroll in Medicare Parts A, B and D when you are first eligible, you can be subject to late enrollment penalties.

Q. Where can I find additional Medicare resources?

A. The following web sites may be helpful: **www.medicare.gov**; **www.ssa.gov**; **www.cms.gov**.

Q. How do I enroll in Medicare?

A. Medicare enrollment is done through the Social Security Administration (SSA). Most people should enroll in Medicare Part A (hospital coverage) during the Initial Enrollment Period (IEP). SSA will send you enrollment instructions at the beginning of your IEP. This is the period during which you can enroll in Medicare for the first time. It is a 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and runs for three months after the month you turned 65. For example, if you were born in June, your window to enroll is March 1 through September 30. If you're already receiving Social Security benefits, you will be automatically enrolled in Medicare Part A at the start of your Initial Enrollment Period. However, you will need to contact SSA to sign up for Part B. If you do not receive instructions from the SSA, please call **1-800-772-1213** (TTY **1-800-325-0778**) or go to **www.ssa.gov** to enroll in Medicare. Because enrollment takes time to process, if you plan to retire at 65, we recommend enrolling three months prior to your 65th birthday.

Q. When do I enroll in Medicare Parts A and B? When will coverage be effective?

A. You have an Initial Enrollment Period (IEP) of 7 months to sign up: the three months leading up to the month you turn age 65, the month you turn 65, and three months following the month you turn 65. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A & B effective date, whichever is later.

Q. Do I need to enroll in Medicare with the government or just with this plan?

A. Enrollment in Medicare Part A and Part B through the federal government is required for retirees to be eligible for any retiree Medicare plans, including this plan. To have full coverage, you must sign up for Medicare Parts A and B and continue to pay your Part B premium. When enrolling in the plan, you will need to provide your 11-character Medicare Beneficiary Identifier (MBI), located on your red, white and blue Medicare card along with your effective date. The earliest someone who is turning age 65 can sign up for Parts A & B is three months before the month they will turn age 65.

Q. I am already enrolled in a Medicare plan. Will it continue?

A. You can only be enrolled in one Medicare plan at a time and we offer help as you move to your new plan.

Q. When will my Blue Cross Group Medicare Advantage Open Access (PPO) coverage be effective?

A. Coverage is effective on the first day of the month following the date the application was processed or the Medicare Parts A and B effective date, whichever is later.

Q. When will I get my new Blue Cross Group Medicare Advantage Open Access (PPO) member ID card?

A. You will receive an acknowledgment letter, followed by a confirmation letter and then your new member ID card. You may use your confirmation letter as proof of insurance until your new card arrives. Your plan card is for use with all hospital and medical providers as well as the pharmacy. Remember, you will have a new member number and ID card. Be sure to show your new card and new member ID number to your providers or their office staff and your pharmacy. Remind them that your old ID is no longer valid. If they do not use your new card and number, your benefits cannot be confirmed and there may be delays processing your claims.

Q. What are the costs to Medicare outside of my plan?

A. Part A will not cost you anything if you or your spouse paid into Social Security for a minimum of 10 years. You pay a premium each month for Part B. Your Part B premium will be automatically deducted from your benefit payment if you get benefits from one of these:

- Social Security
- Railroad Retirement Board
- Office of Personnel Management

If you don't get these benefit payments, you will receive a Part B premium bill.

The Part B and Part D monthly premiums change each year and can vary according to income through what's known as IRMAA: income-related monthly adjustment amount. Most people will pay the standard premium amount. Medicare uses the modified adjusted gross income reported on your IRS tax return from two years ago to determine any Part B and Part D surcharge. This is the most recent tax return information provided to Social Security by the IRS. A notice from Medicare will be mailed to those who will pay the IRMAA surcharge(s).

Q. What happens if I do not pay my Part B premiums?

A. Non-payment of Part B premiums and/or IRMAA surcharge will result in termination of coverage.

Q. What is a Medicare Advantage Plan? How is it different from my traditional coverage?

A. Medicare Advantage plans are government-authorized and regulated plans offered by private health insurance companies like Blue Cross and Blue Shield of Oklahoma that expand upon the benefits offered by Medicare Parts A and B. Also known as 'Medicare Part C' plans, they include some medical benefits not traditionally covered by Original Medicare Parts A and B. For example, Blue Cross Group Medicare Advantage Open Access (PPO) includes non-Medicare covered benefits such as the SilverSneakers® fitness program, a 24-hour nurse advice line, and discount programs.

Q. Are Medicare Advantage plans joint? Can my spouse or partner be on a different plan?

A. All Medicare-based plans are individual plans. A retiree and their eligible spouse/partner would each enroll as individuals in a Medicare plan option.

Q. Can I be refused coverage, or my coverage be canceled, due to a pre-existing condition?

A. You cannot be refused coverage because of a pre-existing condition. Your coverage cannot be canceled and your claims for covered services cannot be denied because of a pre-existing condition.

Q. Will I be able to see my current providers?

A. Under Blue Cross Group Medicare Advantage Open Access (PPO), which is an 'non-differentiated' or 'passive' PPO, you can go to any providers who: 1) accept Medicare; 2) agree to see you as a patient; and 3) agree to bill the plan. They do not need to be part of any Blue Cross and Blue Shield network.

Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits. Referrals aren't required for office visits. Prior authorization may be required for certain services from Medicare Advantage-contracted providers with BCBSOK.

Please note: Even Medicare-assigned providers can decide which patients they want to see, except in an emergency. We recommend that you confirm with providers that they will accept your Open Access PPO plan and file claims with the plan. Share the enclosed 'Your Providers, Your Personal Network' flyer with your providers. It explains your Open Access plan and submitting claims.

Q. I am already on a care plan. Will it continue?

A. We offer help from a team of experts who will handle your care as you move to Blue Cross Group Medicare Advantage Open Access (PPO). This help is known as continuity of care or coordination of care.

Q. Will my provider be able to submit claims easily to Blue Cross Group Medicare Advantage Open Access (PPO)?

A. Yes. In fact, we simplified the claims process for providers. Instead of submitting claims to Medicare, providers can now submit directly to the plan. Providers outside of Oklahoma can file claims with their

local BCBS plan and are familiar with this process. We take care of any interactions with Medicare. In addition, we offer providers education and dedicated online resources about open access plans. The customer service number listed on the back of your member ID card is for you or your provider to call with any questions.

Q. Does my plan cover any prescription drugs?

A. Medicare Advantage Prescription Drug (MAPD) plans cover drugs or services that are normally covered by Medicare Part B and Part D.

Q. Which medical services need prior authorization?

A. Prior Authorization (PA) is when a contracted provider needs to get approval from the health plan to deliver a service. The goal is to make sure the service is the best choice for the patient and to avoid costly services that have low value.

Prior Authorization is needed for:

- Advanced Imaging (MRI, MRA, CT scans and PET scans)
- Lab Management Solutions – Molecular and Genomic Lab Testing
- Musculoskeletal – Pain/Joint/Spine Services – excludes exams, physical therapy, and occupational therapy
- Inpatient stay that is not the result of an emergency
- Outpatient Medical Oncology
- Outpatient Radiation Therapy
- Outpatient Sleep Study
- Outpatient Specialty Drugs
- Select Durable Medical Equipment
- Some procedures that are performed as part of an inpatient stay

Twenty-three (23) hour observation and emergency room visits do not need prior authorization.

Your provider will work with the plan to get any PA you may need, and may talk with you about other options if necessary.

Q. What happens if a PA is not completed?

A. Your provider is responsible for getting a prior authorization for you. If they fail to get a PA before providing a service, the plan may not pay the claim and the provider would have to absorb the cost of the service. You are not required to pay for the service if the provider fails to get a PA.

Providers can request a PA by calling customer service at the number listed on your member ID card, or via fax. They may also use our provider service through Availity® Essentials.*

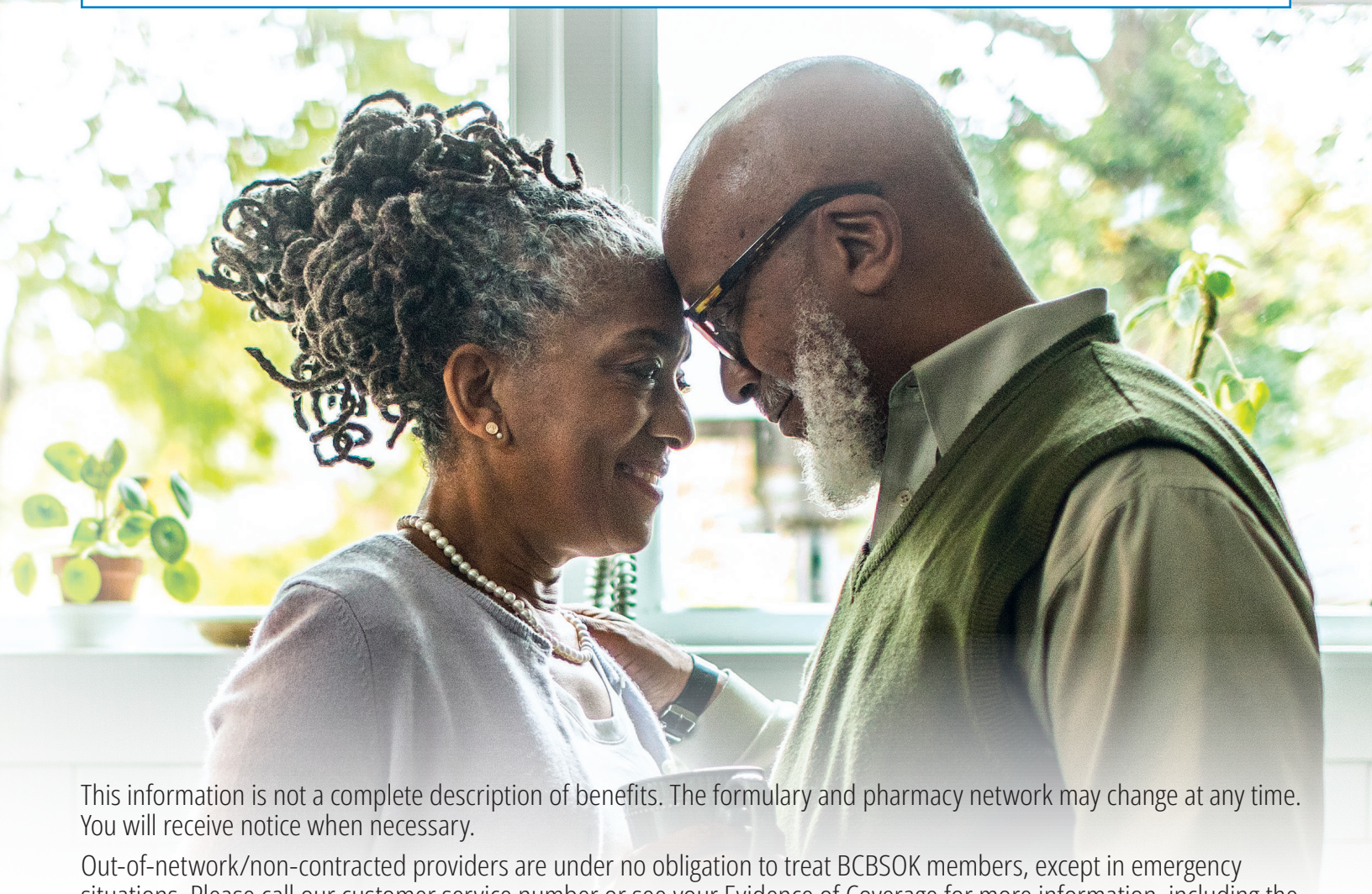
Q. Will I receive a periodic Medicare statement based on the plan I select?

A. You will receive your Explanation of Benefits (EOB) from Blue Cross and Blue Shield of Oklahoma. How often you receive it depends on how often you see your provider or fill a prescription. This statement is not a bill. It simply details what you have paid and indicates the level of benefits you've used.

*Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK. BCBSOK makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

Questions about your retiree group Medicare plan?

Talk to your benefit administrator or refer to the plan documents for details.



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.

Out-of-network/non-contracted providers are under no obligation to treat BCBSOK members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

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 plan) and refers to GHS Insurance Company (GHSIC) (HMO Special Needs Plan and PPO plans). HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC, BlueLincs, and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC, BlueLincs, and GHSIC are Medicare Advantage organizations with a Medicare contract. GHSIC is a Medicare Advantage organization with a Medicare contract and a contract with the Oklahoma Medicaid program. Enrollment in these plans depends on contract renewal.