2021 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Blue Medicare Advantage Essential (PPO)

January 1, 2021 – December 31, 2021

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, http://www.medicarebluekc.com.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Blue Medicare Advantage Essential (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Blue Medicare Advantage Essential (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Blue Medicare Advantage Essential (PPO).**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug Benefits.

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

This document may be available in a non-English language. For additional information, call us at 1-866-508-7140 (TTY: 711).

Things to Know About Blue Medicare Advantage Essential (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Central Time 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. Central Time, Monday through Friday.
- If you are a member of this plan, call us at 1-866-508-7140, TTY: 711.
- If you are not a member of this plan, call us at 1-855-208-8246, TTY: 711.
- Our website: http://www.medicarebluekc.com.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Who can join?

To join **Blue Medicare Advantage Essential (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Kansas: Johnson and Wyandotte
Our service area includes these counties in Missouri: Buchanan, Cass, Clay, Clinton, Jackson, Lafayette, Platte and Ray.

Which doctors, hospitals, and pharmacies can I use?

Blue Medicare Advantage Essential (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (http://www.medicarebluekc.com).Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.medicarebluekc.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Blue Cross and Blue Shield of Kansas City.

SECTION II - SUMMARY OF BENEFITS Blue Medicare Advantage Essential (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for Blue Medicare Advantage Essential (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: $500 (In-network services applying to deductible indicated with "*" asterisk). All out-of-network Medicare-covered services, except zero-dollar preventive services apply to the deductible Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $4,000 for services you receive from in-network providers. • $4,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital*	**In-Network:** **Medical Facility:** Days 1-5: $250 Copay per day for each admission. Days 6-90: $0 Copay per day. Our plan covers an unlimited number of additional days for an inpatient hospital stay at $0 Copay. Prior Authorization is required and the responsibility of your provider. **Mental Health Facility:** Days 1-5: $250 Copay per day for each admission. Days 6-90: $0 Copay per day. Prior Authorization is required and the responsibility of your provider. **Out-of-Network:** **Medical Facility:** 45% Coinsurance per stay. **Mental Health Facility:** 45% Coinsurance per stay.
Ambulatory Surgical Center*	**In-Network:** Ambulatory Surgical Center: $250 Copay.

SECTION II - SUMMARY OF BENEFITS Blue Medicare Advantage Essential (PPO)	
	May require prior authorization. **Out-of-Network:** Ambulatory Surgical Center: 45% Coinsurance.
Outpatient Hospital*	**In-Network:** Observation: $250 Copay. Outpatient hospital: 20% Coinsurance. Outpatient Surgery: $250 Copay. Prior Authorization is required and the responsibility of your provider. **Out-of-Network:** Observation: 45% Coinsurance. Outpatient hospital: 45% Coinsurance. Outpatient Surgery: 45% Coinsurance.
Doctor's Office Visits	**In-Network:** Telehealth visit: $0 Copay. Primary care physician visit: $5 Copay. Specialist visit: $20 - $25 Copay. The lower copay is for Acupuncture Services. The higher copay is for Specialty physician visit. **Out-of-Network:** Primary care physician visit: 45% Coinsurance. Specialist visit: 45% Coinsurance.
Preventive Care *(e.g., flu vaccine, diabetic screenings)*	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 45% Coinsurance for all preventive services covered under Original Medicare out of network.
Emergency Care	**In-Network and Out-of-Network:** $90 Copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.

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	Worldwide Emergency Coverage: $90 Copay.
Urgently Needed Services	**In-Network and Out-of-Network:** $50 Copay per visit. Worldwide Urgent Coverage: $50 Copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 Copay. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $150 - $250 Copay. The lower copay applies for services at your physician's office or a free standing diagnostic center. The higher copay applies at all other facility locations. X-rays: $0 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization. **Out-of-Network:** Diagnostic tests and procedures: 45% Coinsurance. Lab services: 45% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 45% Coinsurance. X-rays: 45% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 45% Coinsurance.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $25 Copay. Routine hearing exam (up to 1 visit every year): $0 Copay. Fitting and Evaluation for Hearing Aid (up to 3 visits every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): $699 - $999 Copay. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 45% Coinsurance. Routine hearing exam (up to 1 visit every year): 45% Coinsurance. Fitting and Evaluation for Hearing Aid (up to 3 visits every year): 45% Coinsurance. Hearing Aid (up to 2 hearing aids every year): $699 - $999 Copay.

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Dental Services	**In-Network:** Medicare Covered: $25 Copay. Our plan pays up to $1,000 every year for preventive and comprehensive dental services for both In and Out of Network Services. Preventive dental services+: • Oral exam (up to 2 visits every year): You Pay Nothing. • Cleaning (up to 2 visits every year): You Pay Nothing. • Fluoride treatment (up to 1 visit every year): You Pay Nothing. • Dental X-rays (up to 1 visit every year): You Pay Nothing. Comprehensive dental services+: • Non-Routine Services (up to 2 visits every year): 50% Coinsurance • Diagnostic Services (up to 2 visits every year): 50% Coinsurance • Restorative Services (up to 2 visits every year): 50% Coinsurance • Endodontic Services (up to 1 visit every year): 50% Coinsurance • Periodontics (up to 2 visits every year): 50% Coinsurance • Extractions (up to 2 visits every year): 50% Coinsurance **Out-of-Network:** Medicare Covered: 45% Coinsurance. Preventive dental services+: • Oral exam (up to 2 visits every year): 45% Coinsurance. • Cleaning (up to 2 visits every year): 45% Coinsurance. • Fluoride treatment (up to 1 visit every year): 45% Coinsurance. • Dental X-rays (up to 1 visit every year): 45% Coinsurance. Comprehensive dental services+: • Non-Routine Services (up to 2 visits every year): : 45% Coinsurance • Diagnostic Services: (up to 2 visits every year): 45% Coinsurance • Restorative Services: (up to 2 visits every year): 45% Coinsurance • Endodontic Services: (up to 1 visit every year): 45% Coinsurance • Periodontics: (up to 2 visits every year): 45% Coinsurance • Extractions: (up to 2 visits every year): 45% Coinsurance + Member is responsible for charges over the Dental Benefit Maximum.
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $25 Copay. The lower copay applies to diabetic eye exams and glaucoma screening. The higher copay for all other Medicare-covered vision services. Routine eye exam (up to 1 visit every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay.

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	Our plan pays up to $300 every year for eyewear In and Out of Network. • Contact lenses: You Pay Nothing+. • Eyeglasses (frames and lenses): You Pay Nothing+. **Out-of-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 45% Coinsurance. Routine eye exam (up to 1 visit every year): 45% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 45% Coinsurance. Our plan pays up to $300 every year for eyewear In and Out of Network. • Contact lenses: 45% Coinsurance • Eyeglasses (frames and lenses): 45% Coinsurance + Member is responsible for charges over the Eyewear Benefit Maximum.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Telehealth visit: $0 Copay. **Out-of-Network:** Outpatient group therapy visit: 45% Coinsurance. Individual therapy visit: 45% Coinsurance.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $184 Copay per day. Prior Authorization is required and the responsibility of your provider. **Out-of-Network:** Days 1-100: 45% Coinsurance per day.
Physical Therapy	**In-Network:** Physical therapy visit: $25 Copay. Telehealth Visit: $0 Copay. **Out-of-Network:** Physical therapy visit: 45% Coinsurance.

<table>
<tr><th colspan="2">SECTION II - SUMMARY OF BENEFITS
Blue Medicare Advantage Essential (PPO)</th></tr>
<tr><td>Ambulance</td><td><u>In-Network and Out-of-Network:</u>
Ground Ambulance: $300 Copay.
Air Ambulance: $300 Copay.
Worldwide Ambulance Coverage: $300 Copay.
May require prior authorization when for non-emergency services.</td></tr>
<tr><td>Transportation</td><td><u>In-Network and Out-of-Network:</u>
You Pay Nothing.
8 One-way trips every year to Plan-approved Health-related Location and requires a referral for services from the Plan’s service provider.</td></tr>
<tr><td>Medicare Part B Drugs</td><td><u>In-Network:</u>
For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
Other Part B drugs: 0% - 20% Coinsurance.
The lower copay applies to vaccines. The higher copay for all other Medicare-covered Part B drug services.
May require prior authorization.
<u>Out-of-Network:</u>
For Part B drugs such as chemotherapy drugs: 45% Coinsurance.
Other Part B drugs: 45% Coinsurance.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan.
Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$3 copay</td><td>$6 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$20 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>$200 copay</td><td>$300 copay</td></tr>
</table></td></tr>
</table>

	<table><tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr></table> **Standard Mail Order** <table><tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$3 copay</td><td>$6 copay</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$20 copay</td><td>$0 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td><td>$200 copay</td><td>$300 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr></table> Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website (http://www.medicarebluekc.com) for complete information about your costs for covered drugs.
Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap.
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $6,550, you pay the greater of: • $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs, or • 5% of the cost.

DISCLAIMERS

Blue Medicare Advantage Essential is a Local PPO plan with a Medicare contract. Enrollment in **Blue Medicare Advantage Essential** depends on contract renewal.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Kansas City members, except in emergency situations. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Missouri Valley Life And Health Insurance Company

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The PPO products are offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiaries of Blue Cross and Blue Shield of Kansas City.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-208-8246 (TTY 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit http://www.medicarebluekc.com or call 1-855-208-8246 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022.
- ☐ **For HMO Plans only**: Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For PPO Plans only**: Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ **For PPO Plans only**: Out-of-network/non-contracted providers are under no obligation to treat **Blue Medicare Advantage (PPO)** members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.