# Blue Medicare Advantage Essential (PPO)

January 1, 2022 – December 31, 2022

## 2022 Summary of Benefits

## Medicare Advantage Plan with Part D Prescription Drug Coverage

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.
Missouri: Andrew, Bates, Buchanan, Cass, Clay, Clinton, Jackson, Johnson (MO), Lafayette, Platte, and Ray.

Kansas: Johnson (KS) and Wyandotte.

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, www.medicarebluekc.com.

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 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.

*Have Questions?*

Call us at 1-855-208-8246, TTY: 711 from 8 a.m. – 8 p.m. Central Time 7 days a week, October 1 to March 31 and from April 1 to September 30, 8 a.m. – 8 p.m. Central Time, Monday through Friday or go online to our website: www.medicarebluekc.com.

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

| SUMMARY OF BENEFITS<br>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: Not Applicable.<br>Prescription Drug Deductible: Not Applicable. |
| **Maximum Out-of-Pocket Responsibility** | Your yearly limit(s) in this plan:<br>• $3,425 for services you receive from in-network providers.<br>• $3,425 for services you receive from in and out-of-network providers combined.<br>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.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| **Prior Authorization** | Some in-network services may require prior authorization and are indicated with a (PA). |

| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Inpatient Hospital (PA)** | **Medical Facility:**<br>Days 1-5: $325 Copay per day for each admission.<br>Days 6-90: $0 Copay per day.<br>Our plan covers an unlimited number of additional days for an inpatient hospital stay at $0 Copay.<br>**Mental Health Facility:**<br>Days 1-5: $325 Copay per day for each admission.<br>Days 6-90: $0 Copay per day. | **Medical Facility:**<br>45% Coinsurance per stay.<br>**Mental Health Facility:**<br>45% Coinsurance per stay. |
| **Ambulatory Surgical Center (PA)** | Ambulatory Surgical Center: $250 Copay – 20% Coinsurance.<br>Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services. | Ambulatory Surgical Center: 45% Coinsurance. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Outpatient Hospital (PA)** | Observation: $325 Copay.<br>Outpatient hospital: 20% Coinsurance.<br>Outpatient Surgery: $325 Copay<br>Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services. | Observation: 45% Coinsurance.<br>Outpatient hospital: 45% Coinsurance.<br>Outpatient Surgery: 45% Coinsurance. |
| **Doctor's Office Visits** | Telehealth visit: $0 Copay.<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $20 - $25 Copay.<br>The lower copay is for Acupuncture Services. The higher copay is for Specialty physician visit. | Primary care physician visit: $25 Copay.<br>Specialist visit: $50 Copay. |
| **Preventive Care** *(e.g., flu vaccine, diabetic screenings)* | You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered. | You pay a $25 Copay for all preventive services covered under Original Medicare, when provided by a Primary Care physician. |
| **Emergency Care** | $120 Copay per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Worldwide Emergency Coverage: $120 Copay. | $120 Copay per visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. |
| **Urgently Needed Services** | $50 Copay per visit.<br>Worldwide Urgent Coverage: $50 Copay. | $50 Copay per visit. |
| **Diagnostic Services / Labs/ Imaging (PA)** | Diagnostic tests and procedures: $0 Copay.<br>Lab services: $0 Copay.<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $100 - $250 Copay.<br>The lower copay applies for services at your physician's office or a free-standing diagnostic | Diagnostic tests and procedures: 45% Coinsurance.<br>Lab services: 45% Coinsurance.<br>Diagnostic Radiology Services (such as MRI, CAT Scan): 45% Coinsurance.<br>X-rays: 45% Coinsurance. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | center. The higher copay applies at all other facility locations.<br>X-rays: $0 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. | Therapeutic radiology services (such as radiation treatment for cancer): 45% Coinsurance. |
| **Hearing Services** | Exam to diagnose and treat hearing and balance issues: $25 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $0 Copay.<br>Fitting and Evaluation for Hearing Aid (up to 3 visits every year): $0 Copay.<br>Hearing Aid (up to 2 hearing aids every year): $0 Copay.<br>Benefit includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. | Exam to diagnose and treat hearing and balance issues: $50 Copay.<br>Routine hearing exam (up to 1 visit every year): $0 Copay.<br>Fitting and Evaluation for Hearing Aid (up to 3 visits every year): $0 Copay.<br>Hearing Aid (up to 2 hearing aids every year): $0 Copay.<br>Benefit includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. |
| **Dental Services** | You pay a $25 copay for Medicare-covered dental services.<br>You pay $0 copay for preventive dental services.<br>• Oral Exams & Cleaning (2 per year)<br>• X-rays and fluoride treatment (1 per year) | You pay a $50 copay for Medicare-covered dental services.<br>You pay 50% coinsurance for preventive dental services.<br>• Oral Exams & Cleaning (2 per year)<br>• X-rays and fluoride treatment (1 per year) |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | You pay 50% coinsurance for covered comprehensive dental services.<br>• Non-routine, Diagnostic, Periodontic Services (2 visits per year)<br>• Restorative Services (filings or crowns) (2 teeth per year)<br>• Endodontic Services (root canal) (1 tooth per year)<br>• Extractions (simple or surgical) (2 teeth per year)<br><br>There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in and out-of-network. | You pay 50% coinsurance for covered comprehensive dental services.<br>• Non-routine, Diagnostic, Periodontic Services (2 visits per year)<br>• Restorative Services (filings or crowns) (2 teeth per year)<br>• Endodontic Services (root canal) (1 tooth per year)<br>• Extractions (simple or surgical) (2 teeth per year)<br><br>There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in and out-of-network. |
| **Vision Services** | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $25 Copay.<br>The lower copay applies to diabetic eye exams and glaucoma screening. The higher copay for all other Medicare-covered vision services.<br>Routine eye exam (up to 1 visit every year): $0 Copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 Copay.<br>You may use your Blue Benefit Bucks card to schedule and pay for eyewear (contacts and glasses) services. There is a $500 per year benefit allowance every year for transportation and eyewear combined. | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $50 Copay.<br>Routine eye exam (up to 1 visit every year): $0 Copay.<br>Eyeglasses or contact lenses after cataract surgery: 45% Coinsurance.<br>You may use your Blue Benefit Bucks card to schedule and pay for eyewear (contacts and glasses) services. There is a $500 per year benefit allowance every year for transportation and eyewear combined. |
| **Mental Health Care** | Outpatient group therapy visit: $25 Copay.<br>Individual therapy visit: $25 Copay.<br>Telehealth visit: $0 Copay. | Outpatient group therapy visit: 45% Coinsurance<br>Individual therapy visit: 45% Coinsurance. |
| **Skilled Nursing Facility (SNF) (PA)** | Days 1-20: $20 Copay per day.<br>Days 21-100: $188 Copay per day. | Days 1-100: 45% Coinsurance per day. |
| **Physical Therapy** | Physical therapy visit: $25 Copay. | Physical therapy visit: 45% Coinsurance. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | Telehealth Visit: $0 Copay. | |
| **Ambulance (PA)** | Ground Ambulance: $300 Copay.<br>Air Ambulance: $300 Copay.<br>Worldwide Ambulance Coverage: $300 Copay.<br>May require prior authorization when for non-emergency services. | Ground Ambulance: $300 Copay.<br>Air Ambulance: $300 Copay. |
| **Transportation** | You may use your Blue Benefit Bucks card to schedule and pay for transportation services to any health location. There is a $500 per year benefit allowance every year for transportation and eyewear combined. | You may use your Blue Benefit Bucks card to schedule and pay for transportation services to any health location. There is a $500 per year benefit allowance every year for transportation and eyewear combined. |
| **Medicare Part B Drugs (PA)** | For Part B drugs such as chemotherapy drugs: 20% Coinsurance.<br>Other Part B drugs: 0% - 20% Coinsurance.<br>The lower copay applies to vaccines. The higher copay for all other Medicare-covered Part B drug services. | For Part B drugs such as chemotherapy drugs: 45% Coinsurance.<br>Other Part B drugs: 45% Coinsurance. |

| PRESCRIPTION DRUG BENEFITS | |
|---|---|
| **Deductible** | Prescription Drug Deductible: Not Applicable. |
| **Initial Coverage** | You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the drug costs paid by both you and our Part D plan.<br>**Standard Retail Cost-Sharing** |

| Tier | One-month supply | Two-month supply | Three-month supply |
|---|---|---|---|
| Tier 1 (Preferred Generic) | $0 Copay | $0 Copay | $0 Copay |
| Tier 2 (Generic) | $10 Copay | $20 Copay | $0 Copay |
| Tier 3 (Preferred Brand)<br>Covered Insulin | $47 Copay<br>$35 Copay | $94 Copay<br>$70 Copay | $141 Copay<br>$105 Copay |
| Tier 4 (Non-Preferred Drug) | $100 Copay | $200 Copay | $300 Copay |

| PRESCRIPTION DRUG BENEFITS | |
|---|---|
| | <table><tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr></table><br>**Standard Mail Order**<br><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>$0 Copay</td><td>$0 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)<br>Covered Insulin</td><td>$47 Copay<br>$35 Copay</td><td>$94 Copay<br>$70 Copay</td><td>$141 Copay<br>$105 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><br>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 100 days) of a drug.<br>This plan participates in the Part D Senior Savings program which offers a $35 copay for a 30-day supply of covered insulin. You pay the same cost during the initial coverage and coverage gap or “donut hole” stages of your benefit. You will pay 5% of the cost of your covered insulin in the catastrophic stage. Your cost may be less if you receive Extra Help from Medicare.<br><br>Please call us or see the plan’s **“Evidence of Coverage”** on our website (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 $4,430.<br>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 $7,050, which is the end of the coverage gap. |
| **Catastrophic Amount** | After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of:<br>• $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or<br>• 5% of the cost. |
| **Supplemental Services** | |
| Other Benefits | Our plan covers other supplemental services. More details on each of the covered services below are in the information kit and available online.<br>• Over the Counter benefits |

| Supplemental Services | |
|---|---|
| | • Personal Emergency Response System<br>• Meals for Chronic Conditions<br>• Member and Caregiver support<br>• Diabetes Care Program<br>• Mindful<br>• Blue Virtual Care<br>• Nutritional Counseling<br>• Smoking Cessation |

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

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.

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association. The PPO product is offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiary 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, 2023.
- ☐ **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.