Blue KC Essential (PPO)

January 1, 2023 – December 31, 2023

2023 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue KC Essential (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.
Kansas: Johnson and Wyandotte.
Missouri: Andrew, Bates, Buchanan, Cass, Clay, Clinton, Henry, Jackson, Johnson (MO), Lafayette, Platte, Ray, St. Clair and Vernon.

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 Blue KC 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 KC Essential (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,425 for services you receive from in-network providers. • $3,425 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.
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:** Days 1-5: $325 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. **Mental Health Facility:** Days 1-5: $325 Copay per day for each admission. Days 6-90: $0 Copay per day.	**Medical Facility:** 45% Coinsurance per stay. **Mental Health Facility:** 45% Coinsurance per stay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Hospital (PA)	Observation: $325 Copay. Outpatient Hospital, all other services: $50 Copay. Outpatient Surgery: $325 Copay. Minimum copay applies to lower-level services (IE wound care), and maximum copay applies to higher level surgical services.	Observation: 45% Coinsurance. Outpatient Hospital: 45% Coinsurance. Outpatient Surgery: 45% Coinsurance.
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $50 - $250 Copay. Minimum copay applies to lower-level services (IE wound care), and maximum copay applies to higher level surgical services.	Ambulatory Surgical Center: 45% Coinsurance.
Doctor's Office Visits	Telehealth visit: $0 Copay. Primary care provider visit: $0 Copay. Specialist visit: $20 - $25 Copay. The lower copay is for Acupuncture Services. The higher copay is for Specialty physician visits.	Primary care physician visit: $25 Copay. 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. 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.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Emergency Care	$125 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. Worldwide Emergency Coverage: $125 Copay.	$125 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.
Urgently Needed Services	$50 Copay per visit. Worldwide Urgent Coverage: $50 Copay.	$50 Copay per visit.
Diagnostic Services / Labs/ Imaging (PA)	Diagnostic tests and procedures: $10 Copay. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $100 - $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: $10 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.	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.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Hearing Services	Exam to diagnose and treat hearing and balance issues: $25 Copay. Routine hearing exam (up to 1 visit(s) 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): $0 Copay. Benefit includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year for both in and out-of-network when scheduled through our hearing partner.	Exam to diagnose and treat hearing and balance issues: $50 Copay. Routine hearing exam (up to 1 visits 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): $0 Copay. Benefit includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year for both in and out-of-network when scheduled through our hearing partner.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Dental Services	You pay a $25 Copay for Medicare-covered dental services. You pay $0 copay for preventive dental services. • Oral Exams & Cleaning • X-rays and fluoride treatment You pay 50% coinsurance for covered comprehensive dental services. • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) • There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in and out-of-network.	You pay a $50 Copay for Medicare-covered dental services. You pay 50% coinsurance for preventive dental services. • Oral Exams & Cleaning • X-rays and fluoride treatment You pay 50% coinsurance for covered comprehensive dental services. • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) • There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in and out-of-network.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Vision Services	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 visits every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay. You may use your Blue Benefit Bucks (BBB) Prepaid 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 for both in and out-of-network.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $50 Copay. Routine eye exam (up to 1 visit every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: 45% Coinsurance. You may use your Blue Benefit Bucks (BBB) Prepaid 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 for both in and out-of-network.
Mental Health Care	Outpatient group therapy visit: $25 Copay. Individual therapy visit: $25 Copay. Telehealth visit: $0 Copay.	Outpatient group therapy visit: 45% Coinsurance. Individual therapy visit: 45% Coinsurance.
Skilled Nursing Facility (SNF) (PA)	Days 1-20: $20 Copay per day. Days 21-100: $196 Copay per day.	Days 1-100: 45% Coinsurance per day.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Physical Therapy	Physical Therapy visit: $25 Copay. Speech Therapy visit: $25 Copay. Occupational Therapy visit: $25 Copay. Telehealth Visit: $0 Copay.	Physical Therapy visit: 45% Coinsurance. Speech Therapy visit: 45% Coinsurance. Occupational Therapy visit: 45% Coinsurance.
Ambulance (PA)	Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay. Worldwide Ambulance Coverage: $300 Copay.	Ground Ambulance: $300 Copay. 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 and may also be used for dental and hearing aids beyond benefit amount.	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 and may also be used for dental and hearing aids beyond benefit amount.
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy and radiation drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance.	For Part B drugs such as chemotherapy and radiation drugs: 45% Coinsurance. Other Part B drugs: 45% Coinsurance.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></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 $4,660. 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>$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)
Covered Insulin</td><td>$47 Copay

$35 Copay</td><td>$94 Copay

$70 Copay</td><td>$141 Copay

$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>$100 Copay, or 33% coinsurance, whichever is greater</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>$0 Copay</td><td>$0 Copay</td><td>$0 Copay</td></tr>
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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.

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.

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.
</td></tr>
<tr><td>Coverage Gap</td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660.

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 $7,400, which is the end of the coverage gap.</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of:
$4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or
5% of the cost.</td></tr>
</table>

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. • Balance and Cognitive Training • Blue KC Virtual Care • Diabetes Care Management • Diabetes Prevention Program • Foot Care for Chronic Conditions • Member and Caregiver support • Member Rewards Program • Mindful by Blue KC • Nutritional Counseling • Over-the-Counter (OTC) Benefit • Personal Emergency Response System (PERS) • Smoking Cessation

Blue KC Essential is a Local PPO plan with a Medicare contract. Enrollment in **Blue KC 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 Customer Services number or see your "Evidence of Coverage" for more information.

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

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. 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.
- [ ] Review the formulary to make sure your drugs are covered.

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, 2024.
- [ ] **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.

Multi-Language Insert

Multi-language Interpreter Services

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 1-866-508-7140, TTY 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY : 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 1-866-508-7140, TTY: 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 711번으로 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 1-866-508-7140, TTY: 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-508-7140, TTY: 711. سيقوم شخص ما يتحدث العربية1. هذه خدمة مجانية بمساعدتك.

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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 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 1-866-508-7140, TTY: 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、1-866-508-7140, TTY: 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。