Simply Blue Advantage (PPO)

January 1, 2022 – December 31, 2022

2022 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Simply Blue Advantage (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 Simply Blue Advantage (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 Simply Blue Advantage (PPO). You must continue to pay your Medicare Part B premium.
Part B Premium Reduction	You receive up to a $75 reduction of your monthly Part B premium. The premium reduction applies only to amounts you pay towards 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: • $7,250 for services you receive from in-network providers. • $7,250 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 1-4: $500 Copay per day for each admission. Days 5-90: $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 1-3: $500 Copay per day for each admission. Days 4-90: $0 Copay per day.	**Medical Facility:** Days 1-4: $500 Copay per day. Days 5-90: $0 Copay per day. **Mental Health Facility:** Days 1-3: $500 Copay per day. Days 4-90: $0 Copay per day.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $300 Copay – 20% coinsurance. Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services.	Ambulatory Surgical Center: $300 Copay – 20% coinsurance. Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services.
Outpatient Hospital (PA)	Observation: $500 Copay. Outpatient hospital: 20% Coinsurance. Outpatient Surgery: $500 Copay Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services.	Observation: $500 Copay. Outpatient hospital: 20% Coinsurance. Outpatient Surgery: $500 Copay. Coinsurance applies to lower level services (IE wound care), copay applies to higher level surgical services.
Doctor's Office Visits	Telehealth visit: $0 Copay. Primary care physician visit: $0 Copay. Specialist visit: $30 Copay.	Primary care physician visit: $0 Copay. Specialist visit: $30 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 $0 copay for all preventive services covered under Original Medicare at zero cost sharing.
Emergency Care	$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. Worldwide Emergency Coverage: $90 Copay.	$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.
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: $0 Copay. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $150 - $300 Copay.	Diagnostic tests and procedures: $0 Copay. Lab services: $0 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $150 - $300 Copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	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.	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.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $30 Copay.	Exam to diagnose and treat hearing and balance issues: $30 Copay.
Dental Services	Medicare Covered: $30 Copay.	Medicare Covered: $30 Copay.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $30 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.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $30 Copay. The lower copay applies to 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.
Mental Health Care	Outpatient group therapy visit: $30 Copay. Individual therapy visit: $30 Copay. Telehealth visit: $0 Copay.	Outpatient group therapy visit: $30 Copay. Individual therapy visit: $30 Copay.
Skilled Nursing Facility (SNF) (PA)	Days 1-20: $0 Copay per day. Days 21-100: $188 Copay per day.	Days 1-20: $0 Copay per day. Days 21-100: $188 Copay per day.
Physical Therapy	Physical therapy visit: $30 Copay. Telehealth Visit: $0 Copay.	Physical therapy visit: $30 Copay.
Ambulance (PA)	Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay. Worldwide Ambulance Coverage: $300 Copay.	Ground Ambulance: $300 Copay. Air Ambulance: $300 Copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	May require prior authorization when for non-emergency services.	
Transportation	Not Covered.	Not Covered.
Medicare Part B Drugs (PA)	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.	For Part B drugs such as chemotherapy drugs: 0% - 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.

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.

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) Covered Insulin	$47 Copay $35 Copay	$94 Copay $70 Copay	$141 Copay $105 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier)	33% Coinsurance	Not Applicable	Not Applicable

Standard Mail Order

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

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>
<table>
<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>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 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 $4,430.
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.</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $7,050, you pay the greater of:
• $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or
• 5% of the cost.</td></tr>
<tr><th colspan="2">Supplemental Services</th></tr>
<tr><td>Other Benefits</td><td>Our plan covers other supplemental services. More details on each of the covered services below are in the information kit and available online.
• Diabetes Care Program
• Mindful
• Blue Virtual Care
• Nutritional Counseling
• Smoking Cessation</td></tr>
</table>

Simply Blue Advantage is a Local PPO plan with a Medicare contract. Enrollment in **Simply Blue Advantage** 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.