Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2022 – December 31, 2022

2022 Summary of Benefits
William Jewell PPO

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join William Jewell PPO, you must be entitled to Medicare Part A and be enrolled in Medicare Part B. Our provider network service area is in the following counties:

Kansas: Johnson and Wyandotte.
Missouri: Andrew, Bates, Buchanan, Cass, Clay, Clinton, Jackson, Johnson, Lafayette, Platte and Ray.

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/wjcretiree.

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 1-866-508-7140, 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/wjcretiree.

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

SUMMARY OF BENEFITS William Jewell PPO	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	Please refer to your former Employer's Benefit department for your premium. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,950 for services you receive from in-network providers. • $6,700 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 for your reference.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Acupuncture for Chronic Low Back Pain	You pay a $40 copay for each Medicare-covered Acupuncture treatment.	You pay 35% coinsurance for each Medicare-covered Acupuncture treatment.
Ambulance Services	You pay a $150 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $150 copay for worldwide ambulance benefit. *Prior authorization may be required for non-emergent transportation by ambulance.*	You pay a $150 copay for ambulance benefits. This copay applies to each one-way trip.
Ambulatory Surgical Services	You pay a $300 copay for surgery. *Prior authorization may be required.*	You pay a $300 copay for surgery.
Annual Physical Exam	There is no coinsurance, copayment, or deductible for the annual physical exam.	You pay a 35% coinsurance for annual physical exam.
Cardiac Rehabilitation Services	You pay a $5 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.	You pay a 35% coinsurance for cardiac rehabilitation and intensive cardiac rehabilitation services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Chiropractic Services	You pay a $20 copay for chiropractic services.	You pay a 35% coinsurance for chiropractic services.
Dental Services	You pay a $40 copay for Medicare-covered dental services. Your plan covers up to $500 per year for preventive and comprehensive dental services in and out of network. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays Comprehensive dental services: • Non-Routine Services • Diagnostic Services • Restorative Services • Endodontic • Periodontics • Extractions	You pay a 35% coinsurance for Medicare-covered dental services. Your plan covers up to $500 per year for preventive and comprehensive dental services in and out of network. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays Comprehensive dental services: • Non-Routine Services • Diagnostic Services • Restorative Services • Endodontic • Periodontics • Extractions
Diabetes Self-management Training, Diabetic Services, Supplies	You pay a $0 copay for each Telehealth visit. You pay a $0 copay for diabetes self-management training. You pay a $0 copay for Bayer/Ascensia diabetes monitoring supplies when obtained at a pharmacy. You pay 0% coinsurance for diabetic supplies when obtained from EdgePark. You pay 20% coinsurance for other diabetic supplies from another DME provider or at a network pharmacy. You pay 20% coinsurance for diabetic, therapeutic custom-molded shoes or inserts. You pay nothing for the Diabetic Care Program or the diabetic device and supplies.	You pay 35% coinsurance for diabetes self-management training, diabetic services and supplies. You pay a $0 copay for Bayer/Ascensia diabetes monitoring supplies when obtained at a pharmacy.
Durable Medical Equipment (DME) and Related Supplies	You pay 20% coinsurance for DME items. *Prior authorization is required.*	You pay 35% coinsurance for DME items.
Emergency Care	You pay a $80 copay for emergency room visits. You pay a $80 copay for worldwide emergency care	You pay a $80 copay for emergency room visits.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Urgently Needed Services	**<u>In-Network:</u>** $40 Copay per visit. $0 copay when you use Blue KC Virtual Care. Worldwide Urgent Coverage: $40 Copay.	**<u>Out-of-Network:</u>** $40 Copay per visit.
Health and wellness education programs	You pay a $0 copay for nutritional counseling. You pay a $0 copay for Mindful Telehealth counseling visit. You pay a $0 copay for access to participating fitness facilities and programs. You pay a $0 copay for access to 24-hour nurseline.	You pay 35% coinsurance for nutritional counseling and in-person counseling. You pay a $0 copay for access to participating fitness facilities and programs. You pay a $0 copay for access to 24-hour nurseline.
Hearing Services	You pay a $40 copay for each Medicare-covered diagnostic hearing exam to diagnose and treat hearing and balance issues. Benefit must be accessed through the plan's partner and includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. You pay a $0 copay for each routine hearing exam. You pay a $0 copay for each fitting and evaluation for hearing aid visit.	You pay a 35% coinsurance for each Medicare-covered hearing exam to diagnose and treat hearing and balance issues. Benefit must be accessed through the plan's partner and includes up to one hearing aid per ear, per year, up to $500 benefit allowance per ear every year. You pay a $0 copay for each routine hearing exam. You pay a $0 copay for each fitting and evaluation for hearing aid visit.
Home Health Agency Care	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered home health visits. *Prior authorization may be required*	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered home health visits.
Home Infusion Therapy	You pay 20% coinsurance for home infusion therapy. *Prior authorization may be required*	You pay 20% coinsurance for home infusion therapy.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Immunizations	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.	There is a 35% coinsurance the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.
Inpatient Hospital	**Medical Facility**: You pay a $250 copay per day, days 1-6 and $0 copay per day, per stay, days 7 & beyond. *Prior authorization is required.* **Mental Health Facility:** You pay a $200 copay per day, days 1-7 and $0 copay per day, per stay, days 8-90. *Prior authorization is required.*	**Medical Facility**: You pay a $250 copay per day, days 1-6 and $0 copay per day, per stay, days 7-90. **Mental Health Facility:** You pay a 35% coinsurance per day, per stay, days 1-90.
Medicare Part B Drugs	You pay a 20% coinsurance for Part B-covered chemotherapy drugs. You pay 0% coinsurance for Part B covered vaccines. You pay a 20% coinsurance for other Part B covered drugs. *Prior authorization and/or Step Therapy may be required for some Part B Drugs.*	You pay 20% coinsurance for Part B covered chemotherapy drugs. You pay 20% coinsurance for other Part B covered drugs.
Opioid Treatment Program Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each covered opioid treatment services.	You pay a 35% coinsurance for opioid treatment services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	You pay a $0 copay for x-rays. You pay 20% coinsurance for Medicare-covered therapeutic radiology services. You pay a $0 copay for lab services. You pay a $300 copay for Medicare-covered Diagnostic Radiology services (CT, MRI, PET). You pay a $150 copay for other diagnostic procedures and tests *Prior authorization may be required*	You pay 35% coinsurance for outpatient diagnostic tests and therapeutic services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Hospital Services	You pay a $300 copay for observation services. You pay 20% coinsurance for all other hospital services. You pay a $300 copay for outpatient hospital surgery. *Prior authorization may be required.*	You pay a $300 copay for observation services. You pay a $300 copay for outpatient hospital surgery. You pay 35% coinsurance for all other hospital services.
Mental Health Care	You pay a $0 copay for Telehealth services. You pay a $40 copay for each individual therapy and counseling visit. You pay a $40 copay for each group therapy and counseling visit.	You pay 35% coinsurance for each individual therapy and counseling visit. You pay 35% coinsurance for each group therapy and counseling visit.
Outpatient Rehabilitation Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each occupational therapy visit. You pay a $40 copay for each physical therapy and/or speech and language pathology visit.	You pay a 35% coinsurance for outpatient rehabilitation services.
Outpatient Substance Abuse Services	You pay a $0 copay for Telehealth services. You pay a $40 copay for each individual therapy visit. You pay a $40 copay for each group therapy visit.	You pay a 35% coinsurance for outpatient substance abuse services.
Partial Hospitalization Services	You pay a $40 copay for each partial hospitalization. *Prior authorization is required.*	You pay a 35% coinsurance for each partial hospitalization.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Physician/Practitioner Services, Including Doctor's Office Visits	You pay a $0 copay for each Telehealth visit. You pay a $5 copay for each primary care provider or other health care provider in a primary care office visit. You pay a $40 copay for each specialist or other health care providers in a Specialist office.	You pay a 35% coinsurance for each primary care provider visit. You pay a 35% coinsurance for each specialist visit.
Podiatry Services	You pay a $40 copay for each Medicare-covered podiatry service.	You pay a 35% coinsurance for each Medicare-covered podiatry service.
Prosthetic Devices and Related Supplies	You pay a 20% coinsurance for prosthetic devices, related supplies. *Prior authorization may be required.*	You pay 35% coinsurance for prosthetic devices, related supplies.
Pulmonary Rehabilitation Services	You pay a $5 copay for pulmonary rehabilitation services.	You pay a 35% coinsurance for pulmonary rehabilitation services.
Services to Treat Kidney Disease	You pay a $0 copay for kidney disease education services. You pay a 0% coinsurance for renal dialysis. You pay a $0 copay for Telehealth services.	You pay a 35% coinsurance for kidney disease education services. You pay a 35% coinsurance for renal dialysis.
Skilled Nursing Facility (SNF) Care	You pay a $0 copay per day, days 1-20 and a $184 copay per day, days 21-100 for a Medicare-covered stay. *Prior authorization is required.*	You pay a 35% coinsurance for Days 1-100 for a Medicare-covered skilled nursing facility (SNF) stay.
Supervised Exercise Therapy (SET)	You pay a $5 copay per day for Supervised Exercise Therapy (SET) services.	You pay 35% coinsurance for Supervised Exercise Therapy (SET) services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Vision Care	You pay a $40 copay for each Medicare-covered eye exam. You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal or lenticular lenses). You pay a $0 copay for routine eye exam every year. You pay nothing for eyeglass frames, lenses, or contact lenses. Your plan pays up to $150 every year for eyewear in and out-of-network.	You pay a 35% coinsurance for each Medicare-covered eye exam. You pay a $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal or lenticular lenses). You pay a 35% coinsurance for each routine eye exam. You pay nothing for eyeglass frames, lenses, or contact lenses. Your plan pays up to $150 every year for eyewear in and out-of-network.
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. Below is a list of Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Immunizations	35% Coinsurance for all preventive services covered under Original Medicare, when out of 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. Below is a list of Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Immunizations

<table>
<tr><th colspan="3">COVERED MEDICAL AND HOSPITAL BENEFITS</th></tr>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td></td><td>Medical nutrition therapy
Medicare Diabetes Prevention Program (MDPP)
Obesity screening and therapy to promote sustained weight loss
Prostate cancer screening exams
Screening and counseling to reduce alcohol misuse
Screening for lung cancer with low dose computed tomography (LDCT)
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
“Welcome to Medicare” preventive visit</td><td>Medical nutrition therapy
Medicare Diabetes Prevention Program (MDPP)
Obesity screening and therapy to promote sustained weight loss
Prostate cancer screening exams
Screening and counseling to reduce alcohol misuse
Screening for lung cancer with low dose computed tomography (LDCT)
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
“Welcome to Medicare” preventive visit</td></tr>
<tr><td>Meals</td><td colspan="2">For members who qualify with certain chronic conditions may receive 2 meals per day, for up to 4 weeks (56 meals total), pre-cooked, pre-packaged meals.

Members who qualify with certain chronic conditions may also choose nutritional shakes for up to 4 weeks (24 shakes).</td></tr>
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<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 $4,430. 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>$2 copay</td><td>$4 copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$6 copay</td><td>$12 copay</td><td>$18 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 copay</td></tr>
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PRESCRIPTION DRUG BENEFITS	

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)	$2 copay	$4 copay	$0 Copay
Tier 2 (Generic)	$6 copay	$12 copay	$18 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable	Not Applicable

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.

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.medicarebluekc.com/wjcretiree) 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.

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.

Our plan covers Tier 1 Preferred Generic and Tier 2 Generic in the coverage gap.

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$2 copay
Tier 2 (Generic)	$6 copay

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.

PRESCRIPTION DRUG BENEFITS	
Catastrophic Amount	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.

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