Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2022 – December 31, 2022

City of Kansas City PPO Plan 1
2022 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join City of Kansas City PPO Plan 1, you must be entitled to Medicare Part A and be enrolled in Medicare Part B. Our 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/cityofkcmo.

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 1-888-892-8907, 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/cityofkcmo.

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 City of Kansas City PPO Plan 1	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	Please contact your Employer's Benefit Department for your premium information. 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: • $2,000 for services you receive from in-network providers. • $10,000 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.
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 $30 copay for each Medicare-covered Acupuncture treatment.	You pay a $30 copay for each Medicare-covered Acupuncture treatment.
Ambulance Services	You pay a $100 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $100 copay for worldwide ambulance services. *Prior authorization may be required for non-emergent transportation by ambulance.*	You pay a $100 copay for ambulance benefits. This copay applies to each one-way trip. You pay a $100 copay for worldwide ambulance services.
Annual Physical Exam	There is no coinsurance, copayment, or deductible for the annual physical exam.	There is no coinsurance, copayment, or deductible for the annual physical exam.
Cardiac Rehabilitation Services	You pay a $30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.	You pay a $30 copay for cardiac rehabilitation and intensive cardiac rehabilitation services.
Chiropractic Services	You pay a $20 copay for chiropractic services.	You pay a $20 copay for chiropractic services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Dental Services	You pay a $30 copay for Medicare-covered dental services. Your plan covers up to $125 every year for preventive dental services in and out of network. • Oral Exams & Cleaning • X-ray & Fluoride	You pay a $30 copay for Medicare-covered dental services. Your plan covers up to $125 every year for preventive dental services in and out of network. • Oral Exams & Cleaning • X-ray & Fluoride
Diabetes Self-management Training, Diabetic Services and 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 Medicare-covered diabetes monitoring supplies when obtained at a pharmacy. You pay 0% coinsurance on diabetic supplies when obtained from EdgePark. You pay 20% coinsurance when obtained from another DME provider or at a network pharmacy. You pay 0% coinsurance for Medicare-covered diabetic, therapeutic custom-molded shoes or inserts. You pay nothing for the Diabetic Care Program or the Medicare-covered diabetic device and supplies.	You pay a $0 copay for Bayer/Ascensia Medicare-covered diabetes monitoring supplies when obtained at a pharmacy. You pay 20% coinsurance for diabetes self-management training, diabetic services and supplies. You pay 0% coinsurance for Medicare-covered diabetic, therapeutic custom-molded shoes or inserts.
Durable Medical Equipment (DME) and Related Supplies	You pay 20% coinsurance for items. *Prior authorization may be required.*	You pay 20% coinsurance for items.
Emergency Care	You pay a $50 copay for emergency room visits. If you are admitted to the same hospital within 24-hours for the same condition, you pay $0 for the emergency room visit. You pay a $50 copay for worldwide emergency care	You pay a $50 copay for emergency room visits. If you are admitted to the same hospital within 24-hours for the same condition, you pay $0 for the emergency room visit. You pay a $50 copay for worldwide emergency care

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Health and wellness education programs	You pay a $0 copay for: • Nutritional counseling, • Mindful, • Health Club Membership/Fitness Classes through SilverSneakers®, • Blue KC 24-Hour Nurseline	You pay a $0 copay for: • Nutritional counseling • Health Club Membership/Fitness Classes through SilverSneakers®, • Blue KC 24-Hour Nurseline You pay a $5 copay for: • In person counseling visit
Hearing Services	Exam to diagnose and treat Medicare-covered hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Fitting and Evaluation for Hearing Aid (up to 3 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $0 copay. 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.	Exam to diagnose and treat Medicare-covered hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Fitting and Evaluation for Hearing Aid (up to 3 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $0 copay. 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.
Home Health Agency Care	You pay $0 copay for members eligible for home health visits. *Prior Authorization may be required.*	You pay $0 copay for members eligible for 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.
Immunizations	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, Hepatitis B and COVID-19 vaccines.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Inpatient Hospital Care	**Medical Facility:** You pay a $165 copay per day, per stay days 1-5. You pay a $0 copay per day, per stay days 6 & beyond. *Prior authorization is required.* **Mental Health Facility:** You pay a $165 copay per day, per stay days 1-5 and You pay a $0 copay per day, per stay, days 6-90. *Prior authorization is required*.	**Medical Facility:** You pay a $165 copay per day for stay, days 1-5. You pay a $0 copay per day per stay, days 6-90. **Mental Health Facility:** You pay a $165 copay per day for stay, days 1-5. You pay a $0 copay per day for stay, days 6-90.
Part B Prescription Drugs	You pay a 20% coinsurance for Part B-covered chemotherapy drugs. You pay 0% coinsurance for other 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 $5 copay for each service.	You pay a $5 copay for each service.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	You pay a $0 copay for x-rays. You pay 20% coinsurance for therapeutic radiology services. You pay $0 copay for lab services. You pay a $100 copay for Diagnostic Radiology services (CT, MRI, PET). You pay a $0 copay for other diagnostic procedures and tests. *Prior authorization may be required.*	You pay a $0 copay for x-rays. You pay 20% coinsurance for therapeutic radiology services. You pay $0 copay for lab services. You pay a $100 copay for Diagnostic Radiology services (CT, MRI, PET). You pay a $0 copay for other diagnostic procedures and tests.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Hospital	You pay a $100 copay for observation services. You pay a $100 copay for Surgery. You pay 20% coinsurance for all other hospital services. *Prior authorization is required.*	You pay a $100 copay for observation services. You pay a $100 copay for Surgery. You pay 20% coinsurance for all other hospital services.
Mental Health Care	You pay a $0 copay for Telehealth services. You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.	You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each Medicare-covered group therapy visit.
Physical, Speech and Occupational Therapy	You pay a $0 copay for Telehealth services. You pay a $30 copay for each occupational therapy visit. You pay a $30 copay for each physical therapy and/or speech and language pathology visit.	You pay a $30 copay for outpatient rehabilitation services.
Outpatient Substance Abuse Services	You pay a $0 copay for Telehealth services. You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.	You pay a $5 copay for each individual therapy visit. You pay a $30 copay for each group therapy visit.
Ambulatory Surgical Centers*	You pay a $100 copay for each ambulatory surgical center visit. *Prior authorization is required.*	You pay a $100 copay for ambulatory surgical center visits.
Meals	You pay nothing for up to 2 meals per day, for up to 4 weeks (56 meals) per year. You pay nothing for nutritional shakes available for up to 4 weeks (24 units) per year.	
Over-the-Counter Items	Your benefit is a $25 per month for eligible OTC items.	

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Partial Hospitalization Services	You pay a $30 copay for each partial hospitalization. *Prior authorization is required*	You pay a $30 copay for each partial hospitalization.
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 professional in a primary care office visit. You pay a $30 copay for each specialist or other health care provider in a specialist office 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 $30 copay for each specialist or other health care provider in a specialist office visit.
Podiatry Services	You pay a $30 copay for each Medicare-covered podiatry service.	You pay a $30 copay for each Medicare-covered podiatry service.
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	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

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• 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	• 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
Prosthetic Devices and related supplies	You pay a 20% coinsurance for prosthetic devices, related supplies. *Prior authorization may be required*	You pay a 20% coinsurance for prosthetic devices, related supplies.
Pulmonary Rehabilitation Services and Supervised Exercise Therapy (SET)	You pay a $30 copay for each pulmonary rehabilitation services. You pay a $30 copay for each SET visit.	You pay a $30 copay for pulmonary rehabilitation services. You pay a $30 copay for each SET visit.
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 $0 copay for kidney disease education services. You pay a 0% coinsurance for renal dialysis.
Skilled Nursing Facility (SNF) Care	You pay a $0 copay per day, Days 1-20; and $125 copay per day, days 21-100 for a Medicare-covered stay. *Prior authorization is required.*	You pay a 20% coinsurance for Days 1-100; for a Medicare-covered stay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Urgently Needed Services	You pay a $10 copay per visit. You pay a $10 copay for each worldwide urgently needed care visit. You pay a $0 copay when you use Blue KC Virtual Care.	You pay a $10 copay per visit.
Vision Care	You pay a $30 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay a $0 copay for a routine eye exam (up to 1 visit(s) every year): You pay a $0 copay for Medicare-covered Eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal, or lenticular lenses). Our plan pays up to $150 for Eyewear (lens and frames or contact lenses) for both in and out-of-network.	You pay a $30 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay a $0 copay for a routine eye exam (up to 1 visit(s) every year). You pay a $0 copay for Medicare-covered Eyeglasses or contact lenses after cataract surgery (applies to single, bifocal, trifocal, or lenticular lenses). Our plan pays up to $150 for Eyewear (lens and frames or contact lenses) for both in and out-of-network.

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)	$5 copay	$10 copay	$10 copay
Tier 2 (Generic)	$10 copay	$20 copay	$20 copay
Tier 3 (Preferred Brand)	$25 copay	$50 copay	$50 copay
Tier 4 (Non-Preferred Drug)	$50 copay	$100 copay	$100 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable	Not Applicable

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>
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>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$10 copay</td><td>$20 copay</td><td>$20 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$25 copay</td><td>$50 copay</td><td>$50 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$50 copay</td><td>$100 copay</td><td>$100 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.

Please call us or see the plan's "Evidence of Coverage" on our website (www.medicarebluekc.com/cityofkcmo) for complete information about your costs for covered drugs.
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<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.

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

Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$5 copay</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.
</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.

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City of Kansas City PPO Plan 1 is a Local PPO plan with a Medicare contract. Enrollment in **City of Kansas City PPO Plan 1** 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.