Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2022 – December 31, 2022

## 2022 Summary of Benefits

# Blue Medicare Advantage (PPO) for Liberty Public Schools

## Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue Medicare Advantage (PPO) for Liberty Public Schools, you must be entitled to Medicare Part A and be enrolled in Medicare Part B.

**SUMMARY OF BENEFITS**

# Blue Medicare Advantage (PPO) for Liberty Public Schools

| MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES | |
|---|---|
| **Monthly Plan Premium** | Please refer to your Employer's Benefit department for your premium. In addition, you must keep paying your Medicare Part B premiums. |
| **Deductible** | Medical Deductible: Not Applicable.<br>Prescription Drug Deductible: Not Applicable. |
| **Maximum Out-of-Pocket Responsibility** | Your yearly limit(s) in this plan:<br>• $4,900 for services you receive from in-network providers.<br>• $4,900 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 for your reference. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Inpatient Hospital** | **Medical Facility:**<br>Days 1-5: $250 copay per day.<br>Days 6 & beyond: $0 copay per day.<br>*Prior authorization is required.*<br>**Mental Health Facility:**<br>Days 1-5: $250 copay per day.<br>Days 6-90: $0 copay per day.<br>*Prior authorization is required.* | **Medical Facility:**<br>Days 1-5: $250 copay per day.<br>Days 6 -90: $0 copay per day.<br>**Mental Health Facility:**<br>Days 1-5: $250 copay per day.<br>Days 6-90: $0 copay per day. |
| **Acupuncture** | Medicare-covered Acupuncture: $20 copay for each treatment.<br>Supplemental Non-Medicare Acupuncture treatment: $20 copay for each up to 12 visits per year. | Medicare-covered Acupuncture: $20 copay for each treatment.<br>Supplemental Non-Medicare Acupuncture treatment: $20 copay for each up to 12 visits per year. |
| **Annual physical exam** | Annual exam: $0 copay | Annual exam: $0 copay |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Ambulatory Surgical Center** | Ambulatory Surgical Center: $200 copay.<br>*Prior authorization is required.* | Ambulatory Surgical Center: $200 copay. |
| **Cardiac rehabilitation services** | Cardiac services: $5 copay for each visit. | Cardiac services: $5 copay for each visit. |
| **Chiropractic services** | Chiropractic: $20 copay for each visit. | Chiropractic: $20 copay for each visit. |
| **Outpatient Hospital** | Observation: $250 copay.<br>Outpatient Hospital, other services: 20% coinsurance.<br>Outpatient Surgery: $250 copay.<br>Coinsurance applies to lower-level services (IE wound care), copay applies to higher level surgical services.<br>*Prior authorization is required.* | Observation: $250 copay.<br>Outpatient Hospital, other services: 20% coinsurance.<br>Outpatient Surgery: $250 copay.<br>Coinsurance applies to lower-level services (IE wound care), copay applies to higher level surgical services. |
| **Doctor's Office Visits** | Telehealth visit: $0 copay.<br>Primary care physician visit: $0 copay.<br>Specialist visit: $25 copay. | Primary care physician visit: $0 copay.<br>Specialist visit: $25 copay. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **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.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered.<br><br>Below is a list of Medicare-covered preventive services:<br>• Abdominal aortic aneurysm screening<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammograms)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Medical nutrition therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and therapy to promote sustained weight loss<br>• Prostate cancer screening exams<br>• Screening and counseling to reduce alcohol misuse<br>• Screening for lung cancer with low dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) | You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered.<br><br>Below is a list of Medicare-covered preventive services:<br>• Abdominal aortic aneurysm screening<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammograms)<br>• Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)<br>• Cardiovascular disease testing<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screening<br>• Depression screening<br>• Diabetes screening<br>• HIV screening<br>• Medical nutrition therapy<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screening and therapy to promote sustained weight loss<br>• Prostate cancer screening exams<br>• Screening and counseling to reduce alcohol misuse<br>• Screening for lung cancer with low dose computed tomography (LDCT)<br>• Screening for sexually transmitted infections (STIs) and counseling to prevent STIs<br>• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| | • "Welcome to Medicare" preventive visit | • "Welcome to Medicare" preventive visit |
| **Emergency Care** | $90 copay per visit.<br>Worldwide Emergency Coverage: $90 copay. | $90 copay per visit. |
| **Urgently Needed Services** | $50 copay per visit.<br>Blue KC Virtual Care: $0 copay<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 copay at a free standing or office clinic- $200 copay at an outpatient facility.<br>X-rays: $0 copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.<br>*Prior authorization may be required for certain services.* | Diagnostic tests and procedures: $0 copay.<br>Lab services: $0 copay.<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay at a free standing or office clinic- $200 copay at an outpatient facility.<br>X-rays: $0 copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. |
| **Health and wellness education programs** | Nutritional counseling: $0 copay<br>Mindful Telehealth counseling visit: $0 copay<br>Fitness facilities and programs: $0 copay<br>Nurseline: $0 copay for access to 24-hour nurse support. | Nutritional counseling: $0 copay<br>Fitness facilities and programs: $0 copay<br>Nurseline: $0 copay for access to 24 hour nurse support. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **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 visit(s) every year): $0 copay.<br>Hearing Aid (up to 2 hearing aids every year): $0 Copay, for up to a $500 per year, per ear benefit maximum when provided by the plan's partner. | 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 visit(s) every year): $0 copay.<br>Hearing Aid (up to 2 hearing aids every year): $0 Copay, for up to a $500 per year, per ear benefit maximum when provided by the plan's partner. |
| **Home health agency care** | Home health visit: $0 copay | Home health visit: $0 copay |
| **Home infusion therapy** | Home infusion: 20% coinsurance | Home infusion: 20% coinsurance |
| **Immunizations** | There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered immunizations. |
| **Dental Services** | Dental services: $25 copay for Medicare-covered visit. | Dental services: $25 copay for Medicare-covered visit. |
| **Diabetes self-management training, diabetic services and supplies** | 20% Coinsurance for DME and prosthetic items<br>$0 copay for Bayer/Ascensia Medicare covered diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.<br>20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider.<br>20% coinsurance for therapeutic custom-molded shoes or inserts.<br>Our plan covers additional Diabetic services under Uniform Flexibility for individuals with Chronic Conditions. | 20% coinsurance for DME and prosthetic items<br>$0 copay for Bayer/Ascensia Medicare covered diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy.<br>20% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider.<br>20% coinsurance for therapeutic custom-molded shoes or inserts. |

| 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.<br>The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams.<br>Routine eye exam (up to 1 visit every year): $0 copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 copay. | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-25 copay.<br>The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams.<br>Routine eye exam (up to 1 visit(s) every year): $0 copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 copay. |
| **Mental Health Care** | Outpatient group therapy visit: $25 copay.<br>Individual therapy visit: $25 copay.<br>Telehealth visit: $0 copay. | Outpatient group therapy visit: $25 copay.<br>Individual therapy visit: $25 copay. |
| **Skilled Nursing Facility (SNF)** | Days 1-20: $0 copay per day.<br>Days 21-100: $188 copay per day.<br>*Prior authorization is required.* | Days 1-20: $0 copay per day.<br>Days 21-100: $188 copay per day. |
| **Physical, Speech and Occupational Therapy** | Physical therapy visit: $25 copay.<br>Speech therapy visit: $25 copay.<br>Occupational therapy visit: $25 copay.<br>Telehealth Visit: $0 copay. | Physical therapy visit: $25 copay.<br>Speech therapy visit: $25 copay.<br>Occupational therapy visit: $25 copay |
| **Ambulance** | 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** | *See Blue Benefit Bucks* | *See Blue Benefit Bucks* |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Medicare Part B Drugs** | For Part B drugs such as chemotherapy drugs: 20% coinsurance.<br>Other Part B drugs: 20% coinsurance.<br>*Prior authorization and/or Step therapy may be required for certain services.* | For Part B drugs such as chemotherapy drugs: 20% coinsurance.<br>Other Part B drugs: 20% coinsurance. |
| **Opioid treatment program services** | Telehealth services: $0 copay<br>Opioid treatment program services: $25 copay per visit | Opioid treatment program services: $25 copay per visit |
| **Over-the-Counter Items** | Your benefit is $100 every 3 months for eligible OTC items. | |
| **Durable Medical Equipment (DME), Prosthetics, and supplies** | 20% Coinsurance for DME and prosthetic items | 20% Coinsurance for DME and prosthetic items |
| **Partial hospitalization services** | Partial hospitalization: $25 copay for each visit.<br>*Prior authorization is required and is the responsibility of your physician.* | Partial hospitalization: $25 copay for each visit. |
| **Podiatry Services** | Podiatry service: $25 copay for each Medicare-covered service.<br>Routine care: $25 copay visit, up to 6 visits per year.<br>For members who qualify due to certain chronic conditions under the Special Supplemental Benefits for the Chronically Ill benefit, you pay $0 copay for an in-home foot evaluation, including a waterless pedicure up to 12 visits a year. | Podiatry service: $25 copay for each Medicare-covered service.<br>Routine care: $25 copay visit, up to 6 visits per year. |
| **Pulmonary rehabilitation services** | Pulmonary rehabilitation services: $5 copay for each visit. | Pulmonary rehabilitation services: $5 copay for each visit. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Services to treat kidney disease** | Kidney education services: $0 copay per visit<br>Renal dialysis: 20% coinsurance<br>Telehealth services: $0 copay | Kidney education services: $0 copay per visit<br>Renal dialysis: 20% coinsurance |
| **Supervised Exercise Therapy (SET)** | SET services: $5 copay for each visit. | SET services: $5 copay for each visit. |
| **Blue Benefit Bucks** | Your plan offers $500 per year to spend on extra benefits, like dental services, prescription eyewear, or non-Medical transportation (Uber or Lyft) beyond any covered benefit. | |
| **Personal Emergency Response Service** | Your benefit is one PERS Device per year.<br>GPS enabled wearable device that provides security for individuals who are prone to isolation or are subject to falling. The device is connected to a 24/7 call center to provide support in emergencies or help with general information needs/requests. | |
| **Member & Caregiver Support** | Your benefit is 40 hours per year<br>A service of non-clinical individuals who provide assistance with light housekeeping, errand running, or assistance with accessing care (setup for telemedicine appointments, downloading phone apps - like Uber or Lyft) | |

| 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) | $5 copay | $10 copay | $0 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 |

<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>$0 copay</td><td>$0 copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$5 copay</td><td>$10 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$141 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.<br><br>
Please call us or see the plan's "Evidence of Coverage" on our website (www.medicarebluekc.com/LPS) 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.<br><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.<br><br>
Our plan covers Tier 1 Preferred Generic and Tier 2 Generic in the coverage gap.<br><br>
Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (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:
<ul>
<li>$3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs, or</li>
<li>5% of the cost.</li>
</ul>
</td></tr>
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**Blue Medicare Advantage** is a Local PPO plan with a Medicare contract. Enrollment in **Blue Medicare Advantage** depends on contract renewal.

Our network service area include Johnson and Wyandotte (KS) and Andrew, Bates, Buchanan, Cass, Clay, Clinton, Jackson, Johnson, Lafayette, Platte and Ray (MO).

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.

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/LPS.

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/LPS.

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

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.