January 1, 2023 – December 31, 2023

2023 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.

Our network service area is in the following counties.
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/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.

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. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $4,900 for services you receive from in-network providers. • $4,900 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 (PA) for your reference.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Acupuncture	Medicare-covered acupuncture: $20 copay for each treatment. Supplemental non-Medicare acupuncture treatment: $20 copay for each up to 12 visits per year.	Medicare-covered acupuncture: $20 copay for each treatment. Supplemental non-Medicare acupuncture treatment: $20 copay for each up to 12 visits per year.
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**
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $200 copay.	Ambulatory Surgical Center: $200 copay.
Annual Physical Exam	Annual exam: $0 copay	Annual exam: $0 copay
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.	
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.
Dental Services	Dental services: $25 copay for Medicare-covered visit. Your plan offers $500 per year to spend on extra benefits, like dental services, prescription eyewear, or non-medical transportation beyond any covered benefit.	Dental services: $25 copay for Medicare-covered visit. Your plan offers $500 per year to spend on extra benefits, like dental services, prescription eyewear, or non-medical transportation beyond any covered benefit.
Diabetes Self-Management Training, Diabetic Services and Supplies	$0 copay for preferred brand diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. 20% coinsurance for all other brands of diabetes monitoring	$0 copay for preferred brand diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. 20% coinsurance for all other brands of diabetes monitoring

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	supplies when obtained at a pharmacy or any brand at a DME provider. 20% coinsurance for therapeutic custom-molded shoes or inserts. Our plan covers additional Diabetic services under Uniform Flexibility for individuals with Chronic Conditions.	supplies when obtained at a pharmacy or any brand at a DME provider. 20% coinsurance for therapeutic custom-molded shoes or inserts.
Diagnostic Services / Labs/ Imaging (PA)	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay at a free standing or office clinic- $200 copay at an outpatient facility. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $100 copay at a free standing or office clinic- $200 copay at an outpatient facility. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance.
Doctor's Office Visits	Telehealth visit: $0 copay. Primary care physician visit: $0 copay. Specialist visit: $25 copay.	Primary care physician visit: $0 copay. Specialist visit: $25 copay.
Durable Medical Equipment (DME), Prosthetics, and Supplies	20% coinsurance for DME and prosthetic items	20% coinsurance for DME and prosthetic items
Emergency Care	$90 copay per visit.	$90 copay per visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Worldwide Emergency Coverage: $90 copay.	
Health And Wellness Education Programs	Nutritional counseling: $0 copay Mindful Telehealth counseling visit: $0 copay Fitness facilities and programs: $0 copay Blue KC Virtual Care services: $0 copay	Nutritional counseling: $0 copay Fitness facilities and programs: $0 copay
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 visit(s) every year): $0 copay. 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. 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, 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 the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Inpatient Hospital (PA)	**Medical Facility:** Days 1-5: $250 copay per day. Days 6 & beyond: $0 copay per day. **Mental Health Facility:** Days 1-5: $250 copay per day. Days 6-90: $0 copay per day.	**Medical Facility:** Days 1-5: $250 copay per day. Days 6-90: $0 copay per day. **Mental Health Facility:** Days 1-5: $250 copay per day. Days 6-90: $0 copay per day.
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.	For Part B drugs such as chemotherapy drugs: 20% coinsurance. Other Part B drugs: 20% coinsurance.
Member & Caregiver Support	Your benefit is 40 hours per year. 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)	
Mental Health Care	Outpatient group therapy visit: $25 copay. Individual therapy visits: $25 copay. Telehealth visit: $0 copay.	Outpatient group therapy visit: $25 copay. Individual therapy visits: $25 copay.
Opioid Treatment Program Services	Telehealth services: $0 copay Opioid treatment program services: $25 copay per visit	Opioid treatment program services: $25 copay per visit
Outpatient Hospital (PA)	Observation: $250 copay. Outpatient Hospital, other services: 20% coinsurance. Outpatient Surgery: $250 copay. Coinsurance applies to lower-level services (i.e., wound care),	Observation: $250 copay. Outpatient Hospital, other services: 20% coinsurance. Outpatient Surgery: $250 copay. Coinsurance applies to lower-level services (i.e., wound care),

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	copay applies to higher level surgical services.	copay applies to higher level surgical services.
Over-the-Counter Items	Your benefit is $100 every 3 months for eligible OTC items.	
Partial Hospitalization Services (PA)	Partial hospitalization: $25 copay for each visit.	Partial hospitalization: $25 copay for each visit.
Personal Emergency Response Service	Your benefit is one PERS Device per year. 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.	
Physical, Speech and Occupational Therapy	Physical therapy visits: $25 copay. Speech therapy visit: $25 copay. Occupational therapy visits: $25 copay. Telehealth Visit: $0 copay.	Physical therapy visits: $25 copay. Speech therapy visit: $25 copay. Occupational therapy visits: $25 copay
Podiatry Services	Podiatry service: $25 copay for each Medicare-covered service. Routine care: $25 copay visit, up to 6 visits per year. 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. Routine care: $25 copay visit, up to 6 visits per year.

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. 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 • 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	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 • 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

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• 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	• 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
Pulmonary Rehabilitation Services	Pulmonary rehabilitation services: $5 copay for each visit.	Pulmonary rehabilitation services: $5 copay for each visit.
Services To Treat Kidney Disease	Kidney education services: $0 copay per visit Renal dialysis: 20% coinsurance Telehealth services: $0 copay	Kidney education services: $0 copay per visit Renal dialysis: 20% coinsurance
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.
Supervised Exercise Therapy (SET)	SET services: $5 copay for each visit.	SET services: $5 copay for each visit.
Transportation	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.	
Urgently Needed Services	$50 copay per visit. Blue KC Virtual Care: $0 copay	$50 copay per visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Worldwide Urgent Coverage: $50 copay.	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-25 copay. The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams. Routine eye exam (up to 1 visit every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Your plan offers $500 per year to spend on extra benefits, like dental services, prescription eyewear, or non-medical transportation beyond any covered benefit.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-25 copay. The minimum copay is for diabetic and glaucoma screenings. The maximum copay is for other Medicare covered eye exams. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Your plan offers $500 per year to spend on extra benefits, like dental services, prescription eyewear, or non-medical transportation beyond any covered benefit.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: Not Applicable.
Initial Coverage	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

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

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)	$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

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>
<table>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</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.
Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you.
Important Message About What You Pay for Insulin - You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on.
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.
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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 $4,660.
After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and up to 25% of the plan's cost for covered generic drugs until your costs total $7,400, 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
<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.
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<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
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PRESCRIPTION DRUG BENEFITS	
	• 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 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.