January 1, 2023 – December 31, 2023

2023 Summary of Benefits

Board of Police Commissioners PPO

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Board of Police Commissioners PPO 2023 Medicare Advantage Plan, 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, Henry, Jackson, Johnson, 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/bopc.

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/bopc.

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

SUMMARY OF BENEFITS Board of Police Commissioners PPO	
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: • $7,550 for services you receive from in-network providers. • $11,300 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**
Inpatient Hospital (PA)	**Medical Facility:** $0 copay per stay. **Mental Health Facility:** $0 copay per stay.	**Medical Facility:** 30% coinsurance per stay. **Mental Health Facility:** 30% coinsurance per stay.
Acupuncture for chronic low back pain	You pay a $20 copay for each Medicare-covered Acupuncture treatment.	You pay a 30% coinsurance for each Medicare-covered Acupuncture treatment.
Annual physical exam	You pay a $0 copay for annual physical exam.	You pay a 30% coinsurance for the annual physical exam.
Outpatient Hospital (PA)	Observation: $0 copay. Outpatient Hospital: $0 copay. Outpatient Surgery: $0 copay.	Observation: 30% coinsurance. Outpatient hospital for other procedures and services: 30% coinsurance. Outpatient Surgery: 30% coinsurance.
Cardiac rehabilitation services	Cardiac services: $20 copay for each visit.	Cardiac services: 30% coinsurance for each visit.
Chiropractic services	Chiropractic: $15 copay for each visit.	Chiropractic: 30% coinsurance for each visit.
Ambulatory Surgical Center (PA)	Ambulatory Surgical Center: $0 copay.	Ambulatory Surgical Center: 30% coinsurance.
Doctor's Office Visits	Telehealth visit: $0 copay. Primary care physician visit: $10 copay. Specialist visit: $20 copay.	Primary care physician visit: 30% coinsurance. Specialist visit: 30% coinsurance.

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 30% coinsurance for all preventive services covered under Original Medicare when out of network. 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
Emergency Care	$50 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: $50 copay.	$50 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.
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 Blue KC Virtual Care services.	You pay a $0 copay for nutritional counseling. You pay a $0 copay for access to participating fitness facilities and programs. You pay a $0 copay for Blue KC Virtual Care services.
Urgently Needed Services	$35 copay per visit. Worldwide Urgent Coverage: $35 copay. Blue KC Virtual Care: $0 copay	$35 copay per visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Diagnostic Services / Labs/ Imaging (PA)	Diagnostic tests and procedures: $20 copay. Lab services: $20 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $20 copay. X-rays: $20 copay. Therapeutic radiology services (such as radiation treatment for cancer): $20 copay.	Diagnostic tests and procedures: 30% coinsurance. Lab services: 30% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 30% coinsurance. X-rays: 30% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 30% coinsurance.
Hearing Services	Medicare-covered exam to diagnose and treat hearing and balance issues: $20 copay. Routine hearing exam: $0 copay. We cover one routine hearing exam every twelve months.	Medicare-covered exam to diagnose and treat hearing and balance issues: 30% coinsurance. Routine hearing exam: 30% coinsurance. We cover one routine hearing exam every twelve months.
Home infusion therapy	You pay a 0% coinsurance for home infusion.	You pay a 30% coinsurance for home infusion.
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.
Home health agency care	You pay a $0 copay for home health care.	You pay a 30% coinsurance for home health care.
Dental Services	Dental services: $20 copay for Medicare-covered visit.	Dental services: 30% coinsurance for Medicare-covered visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Durable Medical Equipment (DME), Prosthetics, and Diabetic Supplies	$0 copay for DME and prosthetic items. $0 copay for preferred 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. $0 copay for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. $0 copay for therapeutic custom-molded shoes or inserts.	30% coinsurance for DME and prosthetic items. 0% coinsurance for preferred 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. 30% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. 30% coinsurance for therapeutic custom-molded shoes or inserts.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay. Routine eye exams: $0 copay. We cover one routine eye exam every 12 months.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 30% coinsurance. Routine eye exams: 30% coinsurance. We cover one routine eye exam every 12 months.
Mental Health Care	Outpatient group therapy visits: $20 copay. Individual therapy visits: $20 copay. Telehealth visits: $0 copay.	Outpatient group therapy visits: 30% coinsurance. Individual therapy visits: 30% coinsurance.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Skilled Nursing Facility (SNF) (PA)	Days 1-100: $0 copay per day.	Days 1-100: 30% coinsurance per day.
	A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	
Outpatient substance abuse services	Individual therapy visits: $20 copay. Group therapy visits: $20 copay. Telehealth services: $0 copay.	Individual therapy visits: 30% coinsurance. Group therapy visits: 30% coinsurance.
Opioid treatment program services	Telehealth services: $0 copay Opioid treatment: $20 copay per visit	Opioid treatment: 30% coinsurance per visit.
Physical, Speech and Occupational Therapy	Physical Therapy visit: $20 copay. Speech Therapy visit: $20 copay. Occupational Therapy visit: $20 copay. Telehealth Visit: $0 copay.	Physical Therapy visit: 30% coinsurance. Speech Therapy visit: 30% coinsurance. Occupational Therapy visit: 30% coinsurance.
Ambulance (PA)	Ground Ambulance: $0 copay. Air Ambulance: $0 copay. Worldwide Ambulance Coverage: $0.	Ground Ambulance: $0 copay. Air Ambulance: $0 copay.
Medicare Part B Drugs (PA)	For Part B drugs such as chemotherapy and radiation drugs: $0 copay. Other Part B drugs: $0 copay.	For Part B drugs such as chemotherapy and radiation drugs: 30% coinsurance. Other Part B drugs: 30% coinsurance.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Partial hospitalization services (PA)	You pay a $20 copay for each Medicare-covered partial hospitalization.	You pay a 30% coinsurance for each partial hospitalization day.
Podiatry Services	Medicare-covered podiatry service: $20 copay.	Medicare-covered podiatry service: 30% coinsurance.
Pulmonary rehabilitation services	Pulmonary rehabilitation services: $20 copay.	Pulmonary rehabilitation services: 30% coinsurance.
Services to treat kidney disease	Kidney disease education services: $0 copay. Renal dialysis: $20 copay. Telehealth services: $0 copay.	Kidney disease education services: 30% coinsurance. Renal dialysis: $20 copay.
Supervised Exercise Therapy (SET)	SET services: $20 copay.	SET services: 30% coinsurance.

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)	$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

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

PRESCRIPTION DRUG BENEFITS	

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.

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/bopc) 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 $4,660.

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

Tier	30-Day Supply	90-Day Retail or Mail
Tier 1 (Preferred Generic)	$2 copay	$0

PRESCRIPTION DRUG BENEFITS			
	Tier 2 (Generic)	$6 copay	$18
	Tier 3 (Preferred Brand)	25%	25%
	Tier 4 (Non-Preferred Drug)	25%	25%
	Tier 5 (Specialty)	25%	N/A
	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.		
Catastrophic Amount	Catastrophic Coverage benefits start once out-of-pocket drug costs reach $7,400. You pay $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.		

Board of Police Commissioners PPO is a Local PPO plan with a Medicare contract. Enrollment in **Board of Police Commissioners PPO** 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 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 1-888-892-8907 (TTY 711).

Understanding the Benefits

- [ ] The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit https://www.medicarebluekc.com/employer-plans or call 1-888-892-8907 (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.
- [ ] Review the formulary to make sure your drugs are covered.

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, 2024.
- [ ] **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.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-508-7140, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-508-7140, TTY: 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-866-508-7140，TTY: 711。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-866-508-7140，TTY: 711。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-508-7140, TTY: 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-508-7140, TTY : 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-866-508-7140, TTY: 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-508-7140, TTY: 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-508-7140, TTY: 711번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-508-7140, TTY: 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-508-7140, TTY: 711. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-508-7140, TTY: 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-508-7140, TTY: 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-508-7140, TTY: 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-508-7140, TTY: 711. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-508-7140, TTY: 711. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-508-7140, TTY: 711にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。