Kansas City | BLUE MEDICARE ADVANTAGE

January 1, 2022 – December 31, 2022

2022 Summary of Benefits
Blue KC Group 25 Retirees

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue KC Group 25 Retirees, 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/bluekcretiree.

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/bluekcretiree.

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 KC Group 25 Retirees	
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: $400 All out-of-network Medicare-covered services, except preventive and emergency services apply to the deductible. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $1,000 for services you receive from in-network providers. • $1,000 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**
Inpatient Hospital	**Medical Facility:** Days 1-6: $0 copay per day. Days 7 & beyond: $0 copay per day. Your deductible applies to this service. *Prior Authorization is required and the responsibility of your provider.* **Mental Health Facility:** Days 1-7: $0 copay per day for each admission. Days 8-90: $0 copay per day. Your deductible applies to this service.	**Medical Facility:** Days 1-90: 20% coinsurance. Your deductible applies to this service. **Mental Health Facility:** Days 1-90: 20% coinsurance. Your deductible applies to this service.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Prior Authorization is required and the responsibility of your provider.	
Ambulatory Surgical Center	Ambulatory Surgical Center: $0 copay. Your deductible applies to this service. *May require prior authorization.*	Ambulatory Surgical Center: 20% coinsurance. Your deductible applies to this service.
Acupuncture for chronic low back pain	You pay a $20 copay for each Medicare-covered Acupuncture treatment. Your deductible applies to this service. You pay $20 copay for each supplemental Non-Medicare Acupuncture treatment up to 12 visits per year.	You pay a 20% co-insurance for each Medicare-covered acupuncture. Your deductible applies to this service. You pay a 20% coinsurance for each supplemental Non-Medicare Acupuncture treatment up to 12 visits per year.
Annual physical exam	There is no coinsurance, copayment, or deductible for the annual physical exam.	You pay a 20% coinsurance for annual physical exam.
Cardiac rehabilitation services	You pay a $0 copay for cardiac rehabilitation and intensive cardiac rehabilitation services. Your deductible applies to this service.	You pay a 20% coinsurance for cardiac rehabilitation and intensive cardiac rehabilitation services. Your deductible applies to this service.
Chiropractic services	You pay a $20 copay for chiropractic services. Your deductible applies to this service.	You pay a 20% coinsurance for chiropractic services. Your deductible applies to this service.
Companion and 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)	
COVID-19 Cost Share Protection	There is no coinsurance, copayment, or deductible for cost-share protection for services related to COVID-19 treatment or testing.	

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient Hospital	Observation: $0 copay. Outpatient Hospital: $0 copay Outpatient Surgery: $0 copay. Your deductible applies to these services. *Prior Authorization is required and the responsibility of your provider.*	Observation: 20% coinsurance. Outpatient Hospital: 20% coinsurance. Outpatient Surgery: 20% coinsurance. Your deductible applies to these services.
Doctor's Office Visits	Telehealth visit: $0 copay. Primary care physician visit: $20 copay. Specialist visit: $20 copay. Your deductible applies to these services.	Primary care physician visit: 20% coinsurance. Specialist visit: 20% coinsurance. Your deductible applies to these services.
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)	20% 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

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	• 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	• 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
Emergency Care	$50 copay per visit. Worldwide Emergency Coverage: $50 Copay.	$50 copay per visit.
Health and wellness education programs	You pay a $0 copay for Nutritional Counseling. You pay a $0 copay for a Mindful Telehealth counseling visit. You pay a $0 copay for Fitness programs. You pay a $0 copay for Nurseline.	You pay 20% coinsurance for nutritional counseling. You pay a 20% coinsurance for in-person counseling visit.
Urgently Needed Services	$20 copay per visit. You pay a $0 copay when you use Blue KC Virtual Care. Worldwide Urgent Coverage: $20 copay.	$20 copay per visit.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Diagnostic Services / Labs/ Imaging	Diagnostic tests and procedures: $0 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): $0 copay. *May require prior authorization.* Your deductible applies to these services.	Diagnostic tests and procedures: 20% coinsurance. Lab services: 20% coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% coinsurance. X-rays: 20% coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. Your deductible applies to these services.
Health and wellness education programs	You pay a $0 copay for a Mindful Telehealth counseling visit. You pay a $0 copay for Nutritional Counseling. You pay a $0 copay for Fitness programs. You pay a $0 copay for Nurseline.	You pay 20% coinsurance for nutritional counseling. You pay a 20% coinsurance for in-person counseling visit
Hearing Services	Exam to diagnose and treat hearing and balance issues: $20 copay. Your deductible applies to this service. 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: 20% coinsurance. Your deductible applies to this service. 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	There is no coinsurance or copayment for Medicare-covered home health services.	You pay 20% coinsurance for Medicare-covered home health visits. Your deductible applies to this service.
Home infusion therapy	You pay 0% coinsurance for home infusion therapy. Your deductible applies to this service.	You pay 20% coinsurance for home infusion therapy. Your deductible applies to this service.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Immunizations	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	There is 20% coinsurance for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Dental Services	Dental services: $20 copay for a Medicare-covered visit. Your deductible applies to this service Preventive: $0 copay, limited to 2 visits per year in and out of network combined. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays	Dental services: 20% coinsurance for Medicare-covered visit. Your deductible applies to this service Preventive: $40 copay, limited to 2 visits per year in and out of network combined. Preventive dental services: • Oral exam • Cleaning • Fluoride treatment • Dental X-rays
Diabetes self-management training, diabetic services and supplies	You pay a $0 copay for each diabetes self-management training Telehealth visit. You pay a $0 copay for diabetes self-management training. You pay nothing for the Diabetic Care Program or the diabetic device and supplies. You pay a $0 copay for Bayer/Ascensia diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. You pay 0% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider. You pay 0% coinsurance for therapeutic custom-molded shoes or inserts.	You pay 0% coinsurance for diabetes self-management training. You pay a $0 copay for Bayer/Ascensia diabetes monitoring devices and supplies, and Continuous Glucose Monitors (CGM) and supplies when obtained at a pharmacy. You pay 0% coinsurance for all other brands of diabetes monitoring supplies when obtained at a pharmacy or a DME provider. You pay 0% coinsurance for therapeutic custom-molded shoes or inserts. You pay 0% coinsurance for diabetic services and supplies.
Durable Medical Equipment (DME) and related supplies	You pay a $0 copay for items. Your deductible applies to this service	You pay a 20% coinsurance for items. Your deductible applies to this service

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): $20 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay. Your deductible applies to these services. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Our plan pays up to $300 every year for eyewear (lens and frames or contact lenses) for both In and Out of Network Services.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 20% Coinsurance. Your deductible applies to these services. Routine eye exam (up to 1 visit(s) every year): 20% Coinsurance. Our plan pays up to $300 every year for eyewear (lens and frames or contact lenses) for both In and Out of Network Services.
Mental Health Care	Outpatient group therapy visit: $20 Copay. Individual therapy visit: $20 Copay. Telehealth visit: $0 Copay. Your deductible applies to these services.	Outpatient group therapy visit: 20% Coinsurance. Individual therapy visit: 20% Coinsurance. Your deductible applies to this service
Skilled Nursing Facility (SNF)	Days 1-100: $0 Copay per day. Your deductible applies to this service. *Prior Authorization is required and the responsibility of your provider.*	Days 1-100: 20% Coinsurance per day. Your deductible applies to this service.
Outpatient substance abuse services	You pay a $0 copay for Medicare-covered Telehealth services. You pay a $20 copay for Medicare-covered substance abuse services. Your deductible applies to this service	You pay a 20% coinsurance for Medicare-covered outpatient substance abuse services. Your deductible applies to this service.
Opioid treatment program services	You pay a $0 copay for Medicare-covered Telehealth services. You pay a $20 copay for each covered opioid treatment services. Your deductible applies to this service.	You pay 20% coinsurance for each covered opioid treatment services. Your deductible applies to this service.
Physical Therapy	Physical therapy visit: $20 Copay. Telehealth Visit: $0 Copay. Your deductible applies to these services.	Physical therapy visit: 20% Coinsurance. Your deductible applies to this service

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Ambulance	Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay. Worldwide Ambulance Coverage: $250 Copay. *May require prior authorization when for non-emergency services.*	Ground Ambulance: $250 Copay. Air Ambulance: $250 Copay.
Transportation	You Pay Nothing. 12 One-way trips every year to Plan-approved Health-related Location and requires a referral for services from the Plan's service provider, in and out of network.	You Pay Nothing. 12 One-way trips every year to Plan-approved Health-related Location and requires a referral for services from the Plan's service provider, in and out of network.
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 0% Coinsurance. Other Part B drugs: 0% Coinsurance. Your deductible applies to these services. *May require prior authorization.*	For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. Your deductible applies to these services.
Partial hospitalization services	You pay a $20 copay for each Medicare-covered partial hospitalization. Your deductible applies to these services.	You pay a 20% coinsurance for each Medicare-covered partial hospitalization. Your deductible applies to these services.
Personal Emergency Response Service (PERS)	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.	
Podiatry Services	You pay a $20 copay for each Medicare-covered podiatry service. Your deductible applies to these services.	You pay a 20% coinsurance for each Medicare-covered podiatry service. Your deductible applies to these services.
Prosthetic devices and related supplies	You pay 0% coinsurance for Medicare-covered prosthetic devices, related medical supplies. Your deductible applies to these services.	You pay 20% coinsurance for Medicare-covered prosthetic devices, related medical supplies. Your deductible applies to these services.
Pulmonary rehabilitation services	You pay a $0 copay for Medicare-covered pulmonary rehabilitation services. Your deductible applies to these services.	You pay a 20% coinsurance for Medicare-covered pulmonary rehabilitation services. Your deductible applies to these services.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Services to treat kidney disease	You pay a $0 copay for Medicare-covered kidney disease education services. You pay a 0% coinsurance for Medicare-covered renal dialysis. You pay a $0 copay for Medicare-covered Telehealth services for kidney disease education. Your deductible applies to these services.	You pay a 20% coinsurance for Medicare-covered renal dialysis. You pay a 20% coinsurance for Medicare-covered kidney disease education. Your deductible applies to these services.
Meals	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).	
Supervised Exercise Therapy (SET)	You pay a $0 copay for Medicare-Covered Supervised Exercise Therapy (SET) services. Your deductible applies to these services.	You pay 20% coinsurance for Medicare-covered Supervised Exercise Therapy (SET) services. Your deductible applies to these services.
Over-the-Counter Items	You pay nothing for a $25 allowance per month (online, in-store and delivery options)	Not Applicable
Transportation – Non-Emergent	There is no copay for each one-way trip to plan approved health-related locations, for up to 12 one-way trips per calendar year.	

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)	$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

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)	$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

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.

1. Please call us or see the plan's **"Evidence of Coverage"** on our website (www.medicarebluekc.com/bluekcretiree) 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)	$0 Copay
Tier 2 (Generic)	$5 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.