Blue KC Essential (PPO)

January 1, 2024 – December 31, 2024

2024 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join Blue KC Essential (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.
Kansas: Johnson and Wyandotte.
Missouri: Andrew, Bates, Benton, Buchanan, Carroll, Cass, Clay, Clinton, Henry, Jackson, Johnson, Lafayette, Pettis, Platte, Ray, Saline, 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.

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 1-855-208-8246, 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.

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

SUMMARY OF BENEFITS Blue KC Essential PPO	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for Blue KC Essential (PPO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,425 for services you receive from in-network providers. • $3,425 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 a (PA) for your reference.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Inpatient hospital care (PA)	$325 per day, days 1-5, $0 per day, days 6 and beyond, per admission	45%, per admission
Inpatient mental health (PA)	$325 per day, days 1-5, $0 per day, days 6-90, per admission	45%, per admission
Outpatient hospital services (PA)	$50 – $325 Minimum copay applies to lower-level services (e.g., wound care) and maximum copay applies to higher level surgical services.	45%

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Ambulatory surgical center (PA)	$50 – $250 Minimum copay applies to lower-level services (e.g., wound care) and maximum copay applies to higher level surgical services.	45%
Physician/Practitioner services, including doctor's office visits	$0 – Telehealth visit $0 – Primary care provider $30 – Specialist visit $20 – Chiropractic services $20 – Medicare-covered Acupuncture	$25 – Primary care provider $50 – Specialist visit 45% – Chiropractic services 45% – Medicare-covered Acupuncture
Preventive care *(e.g., flu vaccine, diabetic screenings)*	$0	$25
Emergency care including Worldwide emergency coverage	$135 If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	$135 If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Urgently needed services including Worldwide urgent coverage	$50 $0 – Blue KC virtual care	$50
Outpatient diagnostic tests and therapeutic services and supplies (PA)	$10 – Diagnostic tests and procedures $0 – Lab services $10 – X-rays 20% – Therapeutic radiology services $100 – $250 - Diagnostic radiology services (e.g., MRI, CAT Scan) The lower copay applies for services at your physician's office or a free-standing diagnostic center. The higher copay applies at all other facility locations.	45% – Diagnostic tests and procedures 45% – Lab services 45% – X-rays 45% – Therapeutic radiology services 45% – Diagnostic radiology services (e.g., MRI, CAT Scan)
Hearing services	$30 – Medicare-covered exam to diagnose and treat hearing and balance issues $0 – Routine hearing exam (up to 1 visit(s) every year) $0 – Fitting and evaluation for hearing aid (up to 12 months after purchase) $0 – Hearing aid (up to 2 hearing aids every year) 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.	$50 – Medicare-covered exam to diagnose and treat hearing and balance issues $0 – Routine hearing exam (up to 1 visit(s) every year) $0 – Fitting and evaluation for hearing aid (up to 12 months after purchase) $0 – Hearing aid (up to 2 hearing aids every year) 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.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Dental services	$30 – Medicare-covered dental services $0 – Preventive dental: • Oral exams & cleaning • X-rays and fluoride treatment 50% – Comprehensive dental: • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in- and out-of-network.	$50 – Medicare-covered dental services 50% – Preventive dental: • Oral exams & cleaning • X-rays and fluoride treatment 50% – Comprehensive dental: • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) There is a $1,000 benefit allowance for preventive and comprehensive dental services every year for both in- and out-of-network.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Vision care	$0 – Diabetic eye exam and glaucoma screening $30 – Medicare-covered eye exam $0 – Medicare-covered eyeglasses or contact lenses after cataract surgery $0 – Routine eye exam (up to 1 visit every year) You may use your flexible benefit on the Blue Benefit Bucks (BBB) prepaid card to pay for eyewear (contacts and glasses) services. There is a $500 per year benefit allowance for dental, hearing aids, transportation, and eyewear combined.	$0 – Diabetic eye exam and glaucoma screening $50 – Medicare-covered eye exam 45% – Medicare-covered eyeglasses or contact lenses after cataract surgery $0 – Routine eye exam (up to 1 visit every year) You may use your flexible benefit on the Blue Benefit Bucks (BBB) prepaid card to pay for eyewear (contacts and glasses) services. There is a $500 per year benefit allowance for dental, hearing aids, transportation, and eyewear combined.
Outpatient mental health care (Individual and Group)	$0 – Telehealth visit $30 – Medicare-covered therapy visit	45% – Medicare-covered therapy visit
Skilled nursing facility (SNF) care (PA)	$20 per day, days 1-20, $203 per day, days 21-100	45% per day, days 1-100
Outpatient rehabilitation services	$0 – Telehealth visit $30 – Medicare-covered physical therapy and/or speech and language pathology visit	45% – Medicare-covered physical therapy and/or speech and language pathology visit
Ambulance services including ground, air and worldwide (PA)	$300	$300

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Transportation	You may use your flexible benefit on the Blue Benefit Bucks (BBB) prepaid card to pay for transportation services to any health-related location. There is a $500 per year benefit allowance for dental, hearing aids, transportation, and eyewear combined.	
Medicare Part B prescription drugs	0-20% The cost-sharing for certain Medicare Part B Prescription Drugs may vary due to Medicare negotiated rate under the Inflation Reduction Act.	45% The cost-sharing for certain Medicare Part B Prescription Drugs may vary due to Medicare negotiated rate under the Inflation Reduction Act.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: Not Applicable.
Initial Coverage	You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$10	$20	$0
Tier 3 (Preferred Brand) Covered Insulin	$47 $35	$94 $70	$141 $105
Tier 4 (Non-Preferred Drug)	$100	$200	$300
Tier 5 (Specialty Tier)	$100, or 33%, whichever is greater	Not Applicable	Not Applicable

PRESCRIPTION DRUG BENEFITS

Preferred Mail Order

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$10	$0	$0
Tier 3 (Preferred Brand) Covered Insulin	$47 $35	$94 $70	$141 $105
Tier 4 (Non-Preferred Drug)	$100	$200	$300
Tier 5 (Specialty Tier)	$100, or 33% coinsurance, whichever is greater	Not Applicable	Not Applicable

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5	$10	$15
Tier 2 (Generic)	$15	$30	$45
Tier 3 (Preferred Brand) Covered Insulin	$47 $35	$94 $70	$141 $105
Tier 4 (Non-Preferred Drug)	$100	$200	$300
Tier 5 (Specialty Tier)	$100, or 33% coinsurance, whichever is greater	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>
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</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.

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) 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 $5,030.

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 $8,000, which is the end of the coverage gap.</td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $8,000:</td></tr>
</table>

PRESCRIPTION DRUG BENEFITS	
	• You will stay in this payment stage until the end of the calendar year • The plan pays the full cost of your covered Part D drugs

Supplemental Services	
Other Benefits	Our plan covers other supplemental services. More details on each of the covered services below are in the information kit and available online. • Balance and cognitive training • Diabetes care management • Footcare for certain conditions • Daily activity support • Mindful by Blue KC • Nutritional counseling • Over-the-Counter (OTC) Benefit • Personal Emergency Response System (PERS) • Smoking cessation

Blue KC Essential (PPO) is a Local PPO plan with a Medicare contract. Enrollment in **Blue KC Essential (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 Medicare Advantage members, except in emergency situations. Please call our Customer Services number or see your "Evidence of Coverage" for more information.

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 1-855-208-8246 (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 http://www.medicarebluekc.com or call 1-855-208-8246 (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, 2025.
- ☐ **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.
- ☐ **Effect on Current Coverage**. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Form Approved
OMB# 0938-1421

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 711 번으로 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.

Portuguese: 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。