William Jewel PPO

January 1, 2024 – December 31, 2024

2024 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

To join William Jewel PPO, 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, Benton, Buchanan, Carroll, Cass, Clay, Clinton, Henry, Jackson, Johnson (MO), 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, medicarebluekc.com/wjc-retiree/.

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: medicarebluekc.com/wjc-retiree/.

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

SUMMARY OF BENEFITS William Jewel 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: • $3,950 for services you receive from in-network providers. • $6,700 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 for chronic low back pain	$40 – Medicare-covered	35% - Medicare-covered
Ambulance services including ground, air and worldwide (PA)	$150	$150
Annual wellness visit	$0	35%
Cardiac rehabilitation services	$5	35%
Chiropractic services	$20 – Medicare-covered	35% – Medicare-covered

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Dental services	$40 – Medicare-covered $0 – Preventive dental services: • Oral exams & cleaning • X-rays and fluoride treatment $0 – Comprehensive dental: • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) $500 benefit allowance for preventive and comprehensive dental services every year for both in- and out-of-network	35% – Medicare-covered $0 – Preventive dental services: • Oral exams & cleaning • X-rays and fluoride treatment $0 – Comprehensive dental: • Non-routine, Diagnostic, Periodontic Services • Restorative Services (fillings or crowns) • Endodontic Services (root canal) • Extractions (simple or surgical) $500 benefit allowance for preventive and comprehensive dental services every year for both in- and out-of-network
Diabetes self-management training, diabetic services, and supplies	$0 – Telehealth visit $0 – Diabetes self-management training $0 – Diabetic Care Program $0 – Medicare-covered preferred brand diabetic devices and supplies. Preferred products include Contour. $0 – Preferred brand Medicare-covered	35% – Diabetes self-management training 35% – Medicare-covered diabetic devices and supplies $0 – Preferred brand Medicare-covered Continuous Glucose Monitors (CGM) when obtained at a pharmacy

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	Continuous Glucose Monitors (CGM) when obtained at a pharmacy 20% – All other brands of Medicare-covered diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. 20% – Medicare-covered therapeutic custom-molded shoes or inserts Our plan covers additional Diabetic services under Uniform Flexibility for individuals with Chronic Conditions.	35% – All other brands of Medicare-covered diabetes monitoring supplies when obtained at a pharmacy or any brand at a DME provider. Non-preferred brand Continuous Glucose Monitors (CGM) are covered only when deemed medically necessary and prior authorized. 35% – Medicare-covered therapeutic custom-molded shoes or inserts
Durable medical equipment (DME) and related supplies (PA)	20%	35%
Emergency care including Worldwide emergency coverage	$80 $0 – Blue KC virtual care	$80
Health and wellness education programs	$0 – Telehealth visit $0 – Nutritional counseling $0 – Participating fitness facilities and programs	35% – Nutritional counseling $0 – Participating fitness facilities and programs

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
	$0– Blue KC Virtual Care services	
Hearing services	$40 – 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) $500 benefit allowance for one hearing aid, per ear, per year. Benefit must be accessed through the plan's partner.	35% – 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) $500 benefit allowance for one hearing aid, per ear, per year. Benefit must be accessed through the plan's partner.
Help with Certain Chronic Conditions	$0 copay for eligible supplemental physical therapy and musculoskeletal support services. Benefit must be accessed through the plan's partner.	$0 copay for eligible supplemental physical therapy and musculoskeletal support services. Benefit must be accessed through the plan's partner.
Home health agency care (PA)	$0	$0
Home infusion therapy (PA)	20%	20%
Immunizations	$0 – Medicare-covered	35% – Medicare-covered

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Inpatient hospital care (PA) - Per admission	$250 per day, days 1-6, $0 per day, days 7 & beyond	$250 per day, days 1-6, $0 per day, days 7-90
Inpatient mental health (PA) - Per admission	$200 per day, days 1-7, $0 per day, days 8-90	35% per day, days 1-90
Medicare Part B prescription drugs (PA)	0% - 20% The cost-sharing for certain Medicare Part B Prescription Drugs may vary due to Medicare negotiated rate under the Inflation Reduction Act.	20% The cost-sharing for certain Medicare Part B Prescription Drugs may vary due to Medicare negotiated rate under the Inflation Reduction Act.
Opioid treatment program services	$0 – Telehealth visit $40 – Treatment program services	35% – Treatment program services
Outpatient diagnostic tests and therapeutic services and supplies (PA)	$0 – Diagnostic tests and procedures $0 – Lab services $0 – X-rays $300 – Diagnostic Radiology Services (such as MRI, CAT Scan) 20% – Therapeutic radiology services (such as radiation treatment for cancer)	35% – Diagnostic tests and procedures 35% – Lab services 35% – X-rays 35% – Diagnostic Radiology Services (such as MRI, CAT Scan) 35% – Therapeutic radiology services (such as radiation treatment for cancer)
Outpatient hospital services (PA)	$300 – Observation 20% – Outpatient hospital services $300 – Outpatient surgery	$300 – Observation 35% – Outpatient hospital services $300 – Outpatient surgery

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Outpatient mental health care (Individual and Group)	$0 – Telehealth visit $40 – Medicare-covered therapy visit	35% – Medicare-covered therapy visit
Outpatient rehabilitation services	$0 – Telehealth visit $40 – Medicare-covered physical therapy and/or speech and language pathology visit $40 – Medicare-covered occupational therapy	35% – Medicare-covered physical therapy and/or speech and language pathology visit 35% - Medicare-covered occupational therapy
Outpatient substance abuse services (Individual and Group)	$0 – Telehealth visit $40 – Medicare-covered substance abuse services	35% – Medicare-covered substance abuse services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	20% – minor procedures when obtained in an outpatient hospital location $300 – surgical services when obtained in an outpatient hospital location $300 – surgical services or minor procedures when obtained in an Ambulatory Surgical Center	35% – minor procedures when obtained in an outpatient hospital location $300 – surgical services when obtained in an outpatient hospital location $300 – surgical services or minor procedures when obtained in an Ambulatory Surgical Center
Partial hospitalization services and Intensive outpatient services (PA)	$40	35%

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Physician/practitioner services, including doctor's office visits	$0 – Telehealth visit $0 – Primary care physician visit or other health care clinician in a primary care office $40 – Specialist visit or other health care clinician in a specialist office	35% – Primary care physician visit or other health care clinician in a primary care office 35% – Specialist visit or other health care clinician in a specialist office
Podiatry services	$40	35%
Preventive care (e.g., flu vaccine, diabetic screenings)	$0 – All Medicare-covered preventive services See Chapter 4 Medical Benefits Chart in your Evidence of Coverage (EOC).	35% – All Medicare-covered preventive services See Chapter 4 Medical Benefits Chart in your Evidence of Coverage (EOC).
Prosthetic devices and related supplies (PA)	20%	35%
Pulmonary rehabilitation services	$5	35%
Services to treat kidney disease	$0 – Telehealth visit $0 – Kidney Disease Education 0% – Renal dialysis	35% – Kidney Disease Education 35% – Renal dialysis
Skilled Nursing Facility (SNF) care (PA)	$0 per day, days 1-20, $184 per day, days 21-100	35% per day, days 1-100
Special Supplemental Benefits for the Chronically Ill – Caregiver Support	$0 copay for eligible members. Benefit must be accessed through the plan's partner.	$0 copay for eligible members. Benefit must be accessed through the plan's partner.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Supervised Exercise Therapy (SET)	$5	35%
Urgently needed services including Worldwide urgent coverage	$40 $0 – Blue KC virtual care	$40
Vision care	$40 – Diabetic eye exam and glaucoma screening $40 – Medicare-covered eye exam $0 – Medicare-covered eyeglasses or contact lenses after cataract surgery $0 – Routine eye exam (up to 1 visit every year) $0 – Eyewear (lens and frames or contact lenses) every year Our plan pays up to $150 every year for eyewear (lens and frames or contact lenses) for both in and out-of-network services.	35% – Diabetic eye exam and glaucoma screening 35% – Medicare-covered eye exam $0 – Medicare-covered eyeglasses or contact lenses after cataract surgery 35% – Routine eye exam (up to 1 visit every year) $0 – Eyewear (lens and frames or contact lenses) every Our plan pays up to $150 every year for eyewear (lens and frames or contact lenses) for both in and out-of-network services.

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>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.

Standard Retail Cost-Sharing

<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>$2</td><td>$4</td><td>$0</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$6</td><td>$12</td><td>$18</td></tr>
<tr><td>Tier 3 (Preferred Brand)

Covered Insulin</td><td>$47

$35</td><td>$94

$70</td><td>$141

$105</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100</td><td>$200</td><td>$300</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td><td>Not Applicable</td><td>Not Applicable</td></tr>
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Standard Mail Order

<table>
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<tr><td></td><td>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 (medicarebluekc.com/wjc-retiree/) 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 up to 25% of the plan's cost for covered generic drugs until your costs total $8,000, 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>$2 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$6 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 $8,000:
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.</td></tr>
</table>

William Jewell PPO is a Local PPO plan with a Medicare contract. Enrollment in **William Jewell 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 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.

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。