BlueCross BlueShield Kansas

# 2027 Summary of Benefits

## Blue Medicare Advantage Comprehensive (PPO)

Jackson, Lyon, Osage, Pottawatomie, Shawnee and Wabaunsee counties

Effective from January 1, 2027 through December 31, 2027


An independent licensee of the Blue Cross Blue Shield Association.

## Introduction

This document is a summary of drug and health services covered by Blue Medicare Advantage Comprehensive (PPO). 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, please request the "Evidence of Coverage."

Blue Medicare Advantage Comprehensive (PPO), offered through Blue Cross and Blue Shield of Kansas, is a PPO plan with a Medicare contract. Enrollment in this plan depends on contract renewal.

This information is not a complete description of benefits. Call **866-943-4144 (TTY: 711)** for more information.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **866-943-4144 (TTY: 711)**.

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Blue Medicare Advantage Comprehensive (PPO) covers and what you pay. If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.

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 https://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**.

## Who can join?

To join Blue Medicare Advantage Comprehensive (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in the state of Kansas: Jackson, Lyon, Osage, Pottawatomie, Shawnee and Wabaunsee.

## Hours of Operations

From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.

From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. You may receive a messaging service on weekends and holidays. Please leave a message and your call will be returned the next business day.

## Phone Numbers and Website

If you have any questions, call toll-free at 866-943-4144 (TTY:711) or visit our website at bcbsks.com/medicare/ma-welcome.

## Which doctors, hospitals, and pharmacies can I use?

Blue Cross and Blue Shield of Kansas has a network of doctors, hospitals, pharmacies, and other providers. As a result, you may pay less for your covered benefits. However, you may also use providers that are not in our network.

Generally, you must use pharmacies in our network to fulfill your prescriptions for covered Part D Drugs.

Please call 866-943-4144 (TTY:711) or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

## What drugs are covered?

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our website, bcbsks.com/medicare.

Or, call us and we will send you a copy of the Formulary.

## How will I determine my drug costs?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, day supply, and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Deductible, Initial Coverage and Catastrophic Coverage. If you have questions about the different benefit stages, please contact the Plan for more information or access the Evidence of Coverage.

# 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 866-943-4144 (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 bcbsks.com/medicare/forms or call 866-943-4144 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, 2028.

- [ ] 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 situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

- [ ] 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.

# Section 2: Summary of Benefits

Notes: Services with a "1" may require prior authorization. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Please see "Section 3: Optional Supplementals" for these additional benefits.

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services | |
| **Monthly Plan Premium** | You must continue to pay your Medicare Part B premium.<br><br>$60 per month |
| **Deductible** | There is no annual deductible. |
| **Maximum Out-of-Pocket (MOOP)** | Your maximum out-of-pocket responsibility represents the most you will pay for copays, coinsurance, and other costs for Medicare-covered services throughout the year. This does not apply to prescription drugs and other select supplemental benefits (as noted).<br><br>$5,000 annually for services you receive from in-network providers.<br><br>$10,750 annually for services you receive from in and out-of-network providers combined. Your limit for services received from in-network providers will count toward this limit. |
| **Inpatient Care** | |
| **Inpatient Hospital Care[1]**<br><br>**Prior Authorization may be required** | Our plan covers an unlimited number of days for an inpatient hospital stay.<br><br>In-network: $350 copay per day for days 1 to 6.<br>$0 copay per day for days 7 and beyond.<br><br>Out-of-network: 50% coinsurance per stay |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Inpatient Mental Health Care[1]**<br>**Prior Authorization may be required** | Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.<br><br>In-network: $350 copay per day for days 1 to 6.<br>$0 copay per day for days 7 to 90.<br><br>Out-of-network: 50% coinsurance per stay |
| **Outpatient Care and Services** | |
| **Outpatient Surgery** | In-network: $275 copay<br>Out-of-network: 50% coinsurance |
| **Ambulatory Surgery Center** | In-network: $275 copay<br>Out-of-network: 50% coinsurance |
| **Doctor's Office Visits** | **Primary Care Provider (PCP):**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**Specialist:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance |
| **Preventive Care** | Our plan covers one annual physical exam per year, in addition to Medicare-covered preventive services<br><br>In-network: $0 copay<br>Out-of-network: 50% coinsurance |
| **Telehealth** | **Primary Care Provider (PCP):**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**Specialist:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Emergency Care** | Services are available worldwide up to $50,000.<br>You do not have to pay your Emergency Room copay if you are admitted to a hospital within 24 hours.<br><br>In-network: $130 copay<br>Out-of-network: $130 copay |
| **Urgently Needed Services** | In-network: $40 copay<br>Out-of-network: $40 copay |
| **Diagnostic Services, Labs, and Imaging**<br>*(Costs for these services may vary based on place of service)*<br><br>**Prior Authorization may be required for MRI's, CT Scans, etc.** | **Diagnostic Tests and Procedures:**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**Lab Services:**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**X-rays:**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a PCP or Specialist's Office:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance<br><br>**Diagnostic Radiology Services (including MRIs, CT Scans, etc.) at a Freestanding or Outpatient Facility:**<br>In-network: $250 copay<br>Out-of-network: 50% coinsurance<br><br>**Therapeutic Radiology Services:**<br>In-network: 20% coinsurance<br>Out-of-network: 50% coinsurance |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Hearing Services** | **Medicare-Covered Exams to Diagnose and Treat Hearing and Balance Issues:**<br><br>In-network: $35 copay<br>Out-of-network: 50% coinsurance<br><br>**Routine Hearing Exams:**<br>Our plan covers one routine hearing exam per year.<br><br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**Hearing Aids:**<br>You pay $295, $695, $1,095 or $1,495 per hearing aid for up to two TruHearing hearing aids every year (one per ear per year). You must see a TruHearing provider to use this benefit.<br><br>***Routine Hearing Exam and Hearing Aid cost-shares are not subject to the maximum out-of-pocket.*** |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Dental Services** | **Medicare-Covered Dental Services:**<br>In-network: 0% coinsurance<br>Out-of-network: 50% coinsurance<br><br>Our plan pays up to $2,500 for preventive and comprehensive dental services every year for services received in-network or out-of-network.<br><br>**Preventive Dental Services:**<br>• Routine cleanings (up to 2 every year)<br>• Bitewing x-rays (up to 2 every year)<br>• Oral exams (up to 2 every year)<br>• Fluoride treatment (up to 2 every year)<br><br>In-network: 0% coinsurance<br>Out-of-network: 50% coinsurance<br><br>**Comprehensive Dental Services:**<br>Reference Evidence of Coverage for additional detail on covered comprehensive services / limitations.<br>• Restorative<br>• Endodontics<br>• Periodontics<br>• Extractions<br>• Prosthodontics and Oral / Maxillofacial Services<br><br>In-network: 0% coinsurance<br>Out-of-network: 50% coinsurance<br><br>***Non Medicare-Covered Preventive and Comprehensive Dental Service cost-shares are not subject to the maximum out-of-pocket.*** |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Vision Services** | **Medicare-Covered Diabetic Eye Exams and Glaucoma Screenings:**<br>In-network: $0 copay<br>Out-of-network: 50% coinsurance<br><br>**All Other Medicare-Covered Eye Exams:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance<br><br>**Medicare-Covered Eyewear:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance<br><br>**Routine Eye Exams:**<br>Our plan covers one routine eye exam per year.<br><br>In-network: $0 copay<br>Out-of-network: You have an exam allowance of $85 every year.<br>Any amount spent over $85 is your responsibility.<br><br>**Frames, Lenses, and Contact Lenses:**<br><br>You have an eyewear allowance of $200 every year.<br>Any amount spent over $200 is your responsibility.<br><br>***Routine Eye Exam and Non-Medicare-Covered Eyewear cost-shares are not subject to the maximum out-of-pocket.*** |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Mental Health Care**[1] | **Outpatient Group Therapy Visit:**<br>In-network: $40 copay<br>Out-of-network: 50% coinsurance<br><br>**Outpatient Individual Therapy Visit:**<br>In-network: $40 copay<br>Out-of-network: 50% coinsurance |
| **Skilled Nursing Facility (SNF)**[1] | Our plan covers up to 100 days in a SNF.<br><br>In-network: $10 copay per day for days 1 to 20.<br>$221 copay per day for days 21 to 100.<br><br>Out-of-network: 50% coinsurance |
| **Outpatient Rehabilitation** | **Occupational Therapy Visit:**<br>In-network: $40 copay for evaluations and therapy visits<br>Out-of-network: 50% coinsurance<br><br>**Physical Therapy and Speech and Language Therapy Visit:**<br>In-network: $40 copay for evaluations and therapy visits<br>Out-of-network: 50% coinsurance |
| **Ambulance** | Ground ambulance: $350 copay per one-way trip<br><br>Air ambulance: 20% coinsurance per one-way trip |
| **Transportation** | Not covered |
| **Prescription Drugs** | |
| **Medicare-Covered Part B Drugs** | **Chemotherapy Drugs:**<br>In-network: 0% to 20% coinsurance<br>Out-of-network: 50% coinsurance<br><br>**Other Part B Drugs:**<br>In-network: 0% to 20% coinsurance<br>Out-of-network: 50% coinsurance |
| **Part D Insulin Drugs** | No more than a $35 copay for select insulin |

| Blue Medicare Advantage Comprehensive (PPO) Outpatient Prescription Drugs – Short-Term Supply | | |
|---|---|---|
| **Phase 1: Deductible Stage** | There is a $700 deductible for tiers 3-5. | |
| **Phase 2: Initial Coverage Stage** | You pay the following until your total yearly drug costs reach $2,400.<br><br>**Note:** Cost-shares may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. In addition, cost-shares may change depending on your Rx day supply or if you are in Long Term Care (LTC). For more information, please call us or access our Evidence of Coverage. | |
| **Phase 3: Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay $0 for your prescription drugs. | |
| | Preferred Retail Rx<br>30-day Supply | Standard Retail Rx<br>30-day Supply |
| *Tier 1: Preferred Generic* | $0 copay | $5 copay |
| *Tier 2: Generic* | $0 copay | $10 copay |
| *Tier 3: Preferred Brand* | 20% coinsurance | 21% coinsurance |
| *Tier 4: Non-Preferred Drug* | 31% coinsurance | 32% coinsurance |
| *Tier 5: Specialty Tier* | 25% coinsurance | 25% coinsurance |
| | Preferred Mail-Order Rx<br>100-day Supply | Standard Mail-Order Rx<br>100-day Supply |
| *Tier 1: Preferred Generic* | $0 copay | $10 copay |
| *Tier 2: Generic* | $0 copay | $20 copay |
| *Tier 3: Preferred Brand* | 20% coinsurance | 21% coinsurance |
| *Tier 4: Non-Preferred Drug* | N/A | N/A |
| *Tier 5: Specialty Tier* | N/A | N/A |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Additional Covered Benefits** | |
| **Cardiac Rehabilitation Services** | Limited to a maximum of two 1-hour sessions per day for up to 36 sessions or up to 36 weeks.<br><br>In-network: $10 copay<br>Out-of-network: 50% coinsurance |
| **Chiropractic Care** | Medicare-covered services are limited to manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).<br><br>In-network: $15 copay<br>Out-of-network: 50% coinsurance |
| **Dialysis** | In-network: 20% coinsurance<br>Out-of-network: 20% coinsurance |
| **Diabetic Supplies and Services[1]** | In-network: 0% to 20% coinsurance<br>Out-of-network: 50% coinsurance<br><br>Diabetic Supplies are covered at 0% to 20% coinsurance, depending on the supplier. 0% coinsurance applies when supplies are manufactured by our preferred supplier, Ascensia. 20% coinsurance applies when Diabetic Supplies are received from all other suppliers at an in-network location. Diabetic Therapeutic Shoes and Inserts are covered in-network at 20% coinsurance. |
| **Durable Medical Equipment (DME) & Prosthetic Devices** | In-network: 20% coinsurance<br>Out-of-network: 50% coinsurance |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
|---|---|
| **Podiatry** | Medicare-covered podiatry services are limited to foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.<br><br>In-network: $35 copay<br>Out-of-network: 50% coinsurance |
| **Home Health Care** | In-network: $0 copay<br>Out-of-network: 50% coinsurance |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Please see the Evidence of Coverage for more information about hospice care and coverage. |
| **Meals** | Our plan covers up to 14 home delivered meals by Mom's Meals over a 7-day period after an inpatient hospital discharge.<br><br>In-network: $0 copay |
| **Opioid Treatment Services** | In-network: $35 copay<br>Out-of-network: 50% coinsurance |
| **Outpatient Substance Abuse** | **Group Therapy Visit:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance<br><br>**Individual Therapy Visit:**<br>In-network: $35 copay<br>Out-of-network: 50% coinsurance |
| **Over-the-Counter (OTC) Drugs** | Our plan covers up to $40 allowance every 3 months for the purchase of over-the-counter drugs. |

| Category | Blue Medicare Advantage Comprehensive (PPO) |
| --- | --- |
| **Fitness Benefit** | Not covered |

# Section 3: Optional Supplementals

## Optional Supplemental Dental Package

For an additional $30 per month, you can purchase an optional supplemental dental package. You must keep paying your Medicare Part B premium and either your $0 premium for your Blue Medicare Advantage (PPO) plan or $60 for your Blue Medicare Advantage Comprehensive (PPO) plan.

The supplemental dental package pays up to **$1,000 of services per year.**
This package covers comprehensive dental services such as:

| **Covered Services** | In-Network Cost Share | Out-of-Network Cost Share |
|---|---|---|
| **Restorative Services** | | |
| Amalgam and Resin Fillings (1 per tooth per surface every 2 years) | 50% coinsurance | 50% coinsurance |
| Crowns (1 per tooth every 5 years) | 50% coinsurance | 50% coinsurance |
| **Endodontics** | | |
| Root Canal (1 per tooth per lifetime) | 50% coinsurance | 50% coinsurance |
| **Periodontics** | | |
| Scaling/Root Planning(2 quadrants per visit, once per quadrant every 24 months) | 50% coinsurance | 50% coinsurance |
| **Extractions** | | |
| Extractions (1 extraction per tooth per year) | 50% coinsurance | 50% coinsurance |
| **Prosthodontics and Maxillofacial Services** | | |
| Dentures (complete and partial) and Bridges (1 every 5 years) | 50% coinsurance | 50% coinsurance |

Members are responsible for the difference between the allowed amount and the billed amount.
For more information, please review the Evidence of Coverage.

# Blue Cross and Blue Shield Medicare Advantage Contact Information

## Call

**866-943-4144**

Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on Thanksgiving, Christmas, and holidays and weekends from April 1 through September 30. Please leave a message and your call will be returned the next business day.

Free language interpreter services available for non-English speakers.

## TTY

**711**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week. You may reach a messaging service on Thanksgiving, Christmas, and holidays and weekends from April 1 through September 30. Please leave a message and your call will be returned the next business day.

## Fax

**1-800-426-6535**

## Write

BCBS Kansas
PO Box 211355
Eagan, MN 55121

## Website

bcbsks.com/medicare/ma-welcome

## IMPORTANT INFORMATION:

### 2027 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Blue Cross and Blue Shield of Kansas - H7063

**For 2027, Blue Cross and Blue Shield of Kansas - H7063 received the following Star Ratings from Medicare:**

| | |
|---|---|
| **Overall Star Rating:** | ★★★☆☆ |
| **Health Services Rating:** | ★★½☆☆ |
| **Drug Services Rating:** | ★★★½☆ |

**Every year, Medicare evaluates plans based on a 5-star rating system.**

**Why Star Ratings Are Important**

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

**The number of stars show how well a plan performs.**

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

**Get More Information on Star Ratings Online**
Compare Star Ratings for this and other plans online at Medicare.gov/plan-compare.

**Questions about this plan?**
Contact Blue Cross and Blue Shield of Kansas 7 days a week from 8:00 a.m. to 8:00 p.m. Central time at 866-943-4144 (toll-free) or 800-766-3777 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time. Current members please call 800-222-7645 (toll-free) or 711 (TTY).

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BlueCross BlueShield Kansas

# 866-943-4144 (TTY: 711)

bcbsks.com/mawelcome

1133 SW Topeka Blvd.
Topeka, KS 66629-0001

