This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BlueKC.com or by calling 1-877-410-6716.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5000** person / **$10000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For preferred providers **$6250** person / **$12500** family For non-preferred providers **$25000** person /**$50000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.BlueKC.com **or call 1-877-410-6716** for a list of preferred providers.	If you use a preferred doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your preferred doctor or hospital may use a non-preferred **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	30% coinsurance	Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab).
	Specialist visit	$80 copay/visit	30% coinsurance	Same limitations as primary care.
	Other practitioner office visit	$80 copay/visit for Chiropractor	30% coinsurance	Same limitations as primary care. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charge	30% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Blood Work: No charge if performed in preferred provider's office/independent lab.
	Imaging (CT/PET scans, MRIs)	$200 copay/day	30% coinsurance	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.BlueKC.com**.	Generic drugs	EA Network $7/National + Network $12 copay retail / $17.50 copay mail order	50% coinsurance retail/mail order	Covers up to 34 day supply (retail) and between 35 to 102 supply (mail order)
	Preferred brand drugs	EA Network $40/National + Network $60 copay retail /$100 copay mail order	50% coinsurance retail/mail order	Covers up to 34 day supply (retail) and between 35 to 102 supply (mail order)
	Non-preferred brand drugs	EA Network $60/National + Network $90 copay retail /$150 copay mail order	50% coinsurance retail/mail order	Covers up to 34 day supply (retail) and between 35 to 102 supply (mail order)
	Specialty drugs	EA Network $80/National + Network $120 copay retail	50% coinsurance retail	Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy. Limited to a one month supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	30% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$400 copay/visit	$400 copay/visit	Other services/procedures that are performed in an Emergency Room are subject to the network deductible and coinsurance level.
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	$60 Copay	30% coinsurance	Same limitations as Primary Care.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/day	30% coinsurance	This copayment applies for up to 5 days per Calendar year. Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, and Maternity Services are combined and count toward the 5 days covered on the applicable Copayment per Calendar Year. After the 5th day, inpatient services will not be subject to any Cost-Sharing for the remainder of the calendar year. Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.
	Physician/surgeon fee	No copay	30% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	$500 copay/day	30% coinsurance	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility. Same limitations as hospital stay.
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	——————none——————
	Substance use disorder inpatient services	$500 copay/day	30% coinsurance	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility. Same limitations as hospital stay.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	Only one specialist copayment shall apply for routine obstetrical services during your pregnancy.
	Delivery and all inpatient services	$500 copay/day	30% coinsurance	Same limitations as hospital stay.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	————————none————————
	Rehabilitation services	10% coinsurance	30% coinsurance	Speech and hearing therapy: 90 visit calendar year maximum; Physical, including skeletal manipulations and Occupational Therapy: unlimited visits
	Habilitation services	10% coinsurance	30% coinsurance	Same limitatons as Rehabilitation services
	Skilled nursing care	Not covered	Not covered	Skilled nursing may be approved in lieu of an inpatient hospital stay.
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.
	Hospice service	10% coinsurance	30% coinsurance	Prior authorization is required for services received at an inpatient facility. Failure to obtain approval, results in the cost of the service being your responsibility.
If your child needs dental or eye care	Eye exam	$25 copay/visit	30% coinsurance	Limited to a child age 18 and younger.
	Glasses	No copay	30% coinsurance	Three pair of lenses per calendar year. Three pair of frames and any additional lens services/features not to exceed $130. Limited to a child age 18 and younger.
	Dental check-up	Not covered	Not covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Glasses (Adult)
- Hearing aids
- Long term care
- Routine eye care(Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care, included in Rehabilitation services
- Non-emergency care when traveling outside the U.S.
- Infertility prescription drugs
- Private duty nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-877-410-6716. You may also contact your state insurance department at 1-800-726-7390 (Missouri Department of Insurance) or 1-800-432-2484 (Kansas Department of Insurance).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Missouri Department of Insurance at 1-800-726-7390 or the Kansas Department of Insurance at 1-800-432-2484. Additionally, a consumer assistance program can help you file your appeal. Contact your insurance department for more information.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-410-6716.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-410-6716.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-410-6716.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-410-6716.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $5140
- **Patient pays** $2400

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays:

Deductibles	$1100
Co-pays	$1100
Co-insurance	$0
Limits or exclusions	$200
Total	**$2400**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact 1-877-410-6716.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $4260
- **Patient pays** $1140

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$0
Co-pays	$1100
Co-insurance	$0
Limits or exclusions	$40
Total	**$1140**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-866-859-3813.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from preferred **providers**. If the patient had received care from non-preferred **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.