Kansas City: Saver PCB Bronze

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 01/01/2016
Coverage for: All Coverage Tiers | **Plan Type:** PPO

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/sgksppo or by calling 1-877-410-6716.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person / **$10,000** family Combined with prescription drugs. 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 **$6,500** person / **$13,200** family For non-preferred providers **$13,000** person / **$26,000** 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 an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **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**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	40% coinsurance	——————none——————
	Specialist visit	10% coinsurance	40% coinsurance	——————none——————
	Other practitioner office visit	10% coinsurance for chiropractor	40% coinsurance for chiropractor	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	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BlueKC.com/H	Generic drugs	$10 copay retail/$25 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	$50 copay retail/$125 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	$80 copay retail/$200 copay mail order	50% coinsurance retail/mail order	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order)

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
PDL.	Specialty drugs	$100 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	40% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	——————none——————
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	10% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Substance use disorder outpatient services	10% coinsurance	40% coinsurance	——————none——————
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	40% coinsurance	——————none——————
	Delivery and all inpatient services	10% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	10% coinsurance	40% coinsurance	Physical, including skeletal manipulations, and Occupational Therapy: unlimited visits. Speech and hearing: 90 visit calendar year maximum.
	Habilitation services	10% coinsurance	40% coinsurance	Same limitations as Rehabilitation services.
	Skilled nursing care	Not Covered	Not Covered	May be approved in lieu of a hospital stay.
	Durable medical equipment	10% coinsurance	40% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Hospice service	10% coinsurance	40% coinsurance	Prior authorization is required for services received at an inpatient facility. Failure to obtain approval may result 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 Charge After Deductible.	30% coinsurance	Limited to three pairs of lenses/frames per calendar year. Limited to a child age 18 and younger.
	Dental check-up	No charge	30% coinsurance	Routine oral exam and teeth cleaning: 2 per calendar year. Limited to a child age 18 and younger.

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 (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 under Rehabilitation services • Infertility treatment limited to prescription drugs	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 plan at 1-877-410-6716, 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 State Department of Insurance.

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.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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:** $7,540
- **Plan pays** $2,120
- **Patient pays** $5,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$20
Coinsurance	$200
Limits or exclusions	$200
Total	**$5,420**

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:** $5,400
- **Plan pays** $360
- **Patient pays** $5,040

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$40
Total	**$5,040**

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 in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

Discrimination is Against the Law

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you’re helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-410-6716.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-410-6716.

Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-877-410-6716。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-410-6716.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-410-6716 an.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Blue KC]에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-877-410-6716 로 전화하십시오.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-877-410-6716.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ1-877-410-6716.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-410-6716.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-410-6716.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-410-6716.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນ ທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ Blue KC, ທ່ານມີ ສິດ ທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານ ທີ່ເປັນພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-410-6716.

Pennsylvanian Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-877-410-6716 uffrufe.

Persian:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمکو اطالعات به زبان خود را به طور رایگان دریافت نمایید 1-877-410-6716. تماس حاصل نمایید.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-877-410-6716 tiin bilbilaa.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-410-6716.

For TTY services, please call 1-816-842-5607.