



**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/sgmoppo](http://www.bluekc.com/sgmoppo) or by calling 1-877-410-6716.

| Important Questions  | Answers   | Why this Matters:   |
|--|---|---|
| <b>What is the overall <u>deductible</u>?</b>                    | For preferred providers<br><b>\$1,500</b> person / <b>\$3,000</b> family.<br>For non-preferred providers<br><b>\$2,500</b> person / <b>\$5,000</b> family<br>Doesn't apply to preventive care | You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .  |
| <b>Are there other <u>deductibles</u> for specific services?</b> | No.   | You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.   |
| <b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>    | Yes. For participating providers <b>\$3,500</b> person / <b>\$7,000</b> family For non-participating providers <b>\$7,000</b> person / <b>\$14,000</b> family                                 | The <b><u>out-of-pocket limit</u></b> 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.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>   | Premiums, balance-billed charges, and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .   |
| <b>Is there an overall annual limit on what the plan pays?</b>   | No.   | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| <b>Does this plan use a <u>network of providers</u>?</b>         | Yes. See <b>www.BlueKC.com</b> or call <b>1-877-410-6716</b> for a list of participating providers.   | If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this plan pays different kinds of <b><u>providers</u></b> . |
| <b>Do I need a referral to see a <u>specialist</u>?</b>          | No. You don't need a referral to see a specialist.  | You can see the <b><u>specialist</u></b> you choose without permission from this plan.  |
| <b>Are there services this</b>                                   | Yes.  | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan  |

**Questions:** Call 1-877-410-6716 or visit us at [www.BlueKC.com](http://www.BlueKC.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-410-6716 to request a copy.



# Kansas City: **Classic PCB Gold**

**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

plan doesn't cover?

document for additional information about excluded services.

**Questions:** Call 1-877-410-6716 or visit us at [www.BlueKC.com](http://www.BlueKC.com).

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- **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  |
|--|--|---|---|---|
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$25 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                                 | \$50 copay/visit                              | 30% coinsurance                                   | Same limitations as primary care.   |
|  | Other practitioner office visit                  | \$50/visit for chiropractor                   | 30% coinsurance for chiropractor                  | Same limitations as primary care. Acupuncture is Not Covered.   |
|  | Preventive care/screening/immunization           | No Charge                                     | 30% coinsurance                                   | —————none—————  |
| <b>If you have a test</b>  | 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 may result in the cost of the service being your responsibility.                      |

| 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  |
|--|--|---|---|---|
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.BlueKC.com/H PDL">www.BlueKC.com/H PDL</a>.</p> | 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 supply (mail order)   |
|  | Specialty drugs                                | \$100 copay                                   | 50% coinsurance retail                            | Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy. Limited to a one month supply.      |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance                               | 30% coinsurance                                   | —————none—————  |
|  | Physician/surgeon fees                         | 10% coinsurance                               | 30% coinsurance                                   | —————none—————  |
| <p><b>If you need immediate medical attention</b></p>  | Emergency room services                        | \$300 copay/visit                             | \$300 copay/visit                                 | Other services/procedures that are performed in an Emergency room may be subject to the network deductible and coinsurance level. |
|  | Emergency medical transportation               | 10% coinsurance                               | 10% coinsurance                                   | —————none—————  |
|  | Urgent care                                    | \$35 copay/visit                              | 30% coinsurance                                   | Same limitations as primary care.   |

| 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  |
|---|--|---|---|---|
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)           | \$400 copay/day                               | 30% coinsurance                                   | This copay applies for up to 5 days per calendar year. Inpatient Hospital, Mental Illness, Substance Abuse and Maternity count towards the 5 days per calendar year. After the 5 <sup>th</sup> 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 may result in the cost of the service being your responsibility. |
|   | Physician/surgeon fee                        | No copay                                      | 30% coinsurance                                   | —————none—————  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 10% coinsurance                               | 30% coinsurance                                   | —————none—————  |
|   | Mental/Behavioral health inpatient services  | \$400 copay/day                               | 30% 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                               | 30% coinsurance                                   | —————none—————  |
|   | Substance use disorder inpatient services    | \$400 copay/day                               | 30% coinsurance                                   | Same limitations as hospital stay. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | 10% coinsurance                               | 30% coinsurance                                   | Only one Specialist copay shall apply for routine obstetrical services during your pregnancy.   |
|   | Delivery and all inpatient services          | \$400 copay/day                               | 30% coinsurance                                   | Same limitation as hospital stay.   |

| 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  |
|---|---------------------------|---|---|---|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 10% coinsurance                               | 30% coinsurance                                   | 90 visit calendar year maximum.   |
|   | Rehabilitation services   | 10% coinsurance                               | 30% coinsurance                                   | Physical Therapy: 20 visit calendar year maximum; Occupational Therapy: 20 visit calendar year maximum; Speech and Hearing Therapy: unlimited visits; Pulmonary Therapy: 20 visit calendar year maximum; Cardiac Therapy: 36 visit calendar year maximum. |
|   | Habilitation services     | 10% coinsurance                               | 30% coinsurance                                   | Same limitations as Rehabilitation services.  |
|   | Skilled nursing care      | 10% coinsurance                               | 30% coinsurance                                   | 90 day calendar year maximum. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.  |
|   | Durable medical equipment | 10% coinsurance                               | 30% coinsurance                                   | Prior authorization is required. Failure to obtain approval may result 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 may result in the cost of the service being your responsibility.   |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$25 copay/visit                              | Not Covered                                       | Limited to one eye exam per calendar year. Limited to a child age 18 and younger.   |
|   | Glasses                   | No charge                                     | Not Covered                                       | Limited to one pair of lenses/frames per calendar year. Limited to a child age 18 and younger.  |
|   | Dental check-up           | No charge                                     | Not Covered                                       | Routine oral exam and teeth cleaning: Limited to 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)
- Infertility treatment
- 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
- Hearing aids ( limited to 1 every 3 years)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing limited to 100 visits per calendar year maximum

## 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](http://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](http://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. For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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, kwijigo holne' 1-877-410-6716.

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

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## 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 \$5,340
- Patient pays \$2,200

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$1,100        |
| Copays               | \$900          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$2,200</b> |

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 \$4,460
- Patient pays \$940

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |              |
|----------------------|--------------|
| Deductibles          | \$0          |
| Copays               | \$900        |
| Coinsurance          | \$0          |
| Limits or exclusions | \$40         |
| <b>Total</b>         | <b>\$940</b> |

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.

**Questions:** Call 1-877-410-6716 or visit us at [www.BlueKC.com](http://www.BlueKC.com).

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SBC-GRP-001

SBC-GRP-002

**Questions:** Call 1-888-989-8842 or visit us at [www.BlueKC.com](http://www.BlueKC.com).

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## **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](mailto: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](mailto: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 위해서는 1-877-410-6716 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 تساعدك أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-410-6716.

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, ຫຼື ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ Blue KC, ທ່ານມີ ສິດ ທ່ານຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນ ກ່ຽວກັບ ທ່ານບໍ່ພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນຮູ້ກ່ຽວກັບພາສາ, ໃຫ້ ໂທຫາ 1-877-410-6716.

Pennsylvanian Dutch: Wann du hoscht en Froog, odder ebber, wu du helpscht, 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 کمک اطلاعات 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.