




⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.BlueKC.com/sgkspoo. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.BlueKC.com/Glossary or call 1-877-410-6716 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$750/Individual or \$1,500/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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.
What is the out-of-pocket limit for this plan ?	For network providers \$6,500 individual / \$13,000 family; for out-of-network providers \$13,000 individual / \$26,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing 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 .
Will you pay less if you use a network provider ?	Yes. See www.BlueKC.com or call 1-877-410-6716 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see a specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay /office visit; Deductible does not apply	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 /office visit; Deductible does not apply	30% coinsurance	Same limitations as primary care.
	Preventive care/screening/immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	30% coinsurance	Blood Work: No charge if performed in preferred provider's office/independent lab after your office visit copay .
	Imaging (CT/PET scans, MRIs)	\$300 copay /day; Deductible does not apply	30% coinsurance	Prior authorization is required. Failure to obtain approval may result 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/KSDL	Generic drugs (Tier 1)	\$10 copay /prescription (retail) / \$25 copay /prescription (mail order). Deductible does not apply.	50% coinsurance (retail)	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order). Generic Specialty (limited to 30-day supply) at retail. \$20 copay /prescription; Deductible does not apply.
	Preferred brand drugs (Tier 2)	\$55 copay /prescription (retail) \$137.50 copay /prescription (mail order). Deductible does not apply.	50% coinsurance (retail)	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order).
	Non-preferred brand drugs (Tier 3)	20% coinsurance /prescription (retail) maximum \$250 / 20% coinsurance /prescription (mail order) maximum	50% coinsurance (retail)	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order). Preferred Brand Specialty (limited to 30-day supply) at retail. 40% coinsurance /prescription maximum \$500; Deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
		\$625. Deductible does not apply.		
	Specialty drugs (Tier 4)	30% coinsurance /prescription (retail)	50% coinsurance (retail)	Covers Non-Preferred Brand Specialty (limited to 30-day supply)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance	None
	Physician/surgeon fees	No charge after deductible	30% coinsurance	None
If you need immediate medical attention	Emergency room care	\$500 copay /visit; Deductible does not apply	\$500 copay /visit; Deductible does not apply	Other services/procedures that are performed in an Emergency room may be subject to the network deductible and coinsurance level.
	Emergency medical transportation	No charge after deductible	No charge after deductible	None
	Urgent care	\$60 copay /visit; Deductible does not apply	30% coinsurance	Same limitations as primary care..
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,100 copay /day; Deductible does not apply	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 th 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 fees	No copay	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$60 copay /visit; Deductible does not apply	30% coinsurance	None
	Inpatient services	\$1,100 copay /day; Deductible does not apply	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
If you are pregnant	Office visits	\$60 copay /visit; Deductible does not apply	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Only one Specialist copay shall apply for routine obstetrical services during your pregnancy.
	Childbirth/delivery professional services	\$1,100 copay /day; Deductible does not apply	30% coinsurance	None
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% coinsurance	None
	Rehabilitation services	No charge after deductible	30% coinsurance	Speech and hearing therapy: 90 visit calendar year maximum
	Habilitation services	No charge after deductible	30% coinsurance	Same limitations as Rehabilitation services.
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	No charge after deductible	30% coinsurance	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Hospice services	No charge after deductible	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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$25 copay /visit; Deductible does not apply	30% coinsurance	Limited to a child age 18 and younger.
	Children's glasses	No charge	30% coinsurance	Limited to three pairs of lenses per calendar year. Limited to three pairs of frames and any additional leans services/features not to exceed \$130. Limited to a child age 18 and younger.
	Children's dental check-up	No charge	30% coinsurance	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult) Hearing aids Long-term care 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Chiropractic care included under Rehabilitation services Infertility treatment (limited to prescription drugs) 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: your [plan](#) at 1-888-989-8842, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Missouri Department of Insurance at 1-800-726-7390 or the Kansas Department of Insurance at 1-800-432-2484.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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, kwijjigo holne' 1-877-410-6716.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#) [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

The total Joe would pay is **\$1,390**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copay](#) \$80
- [Hospital \(facility\) copay](#) \$1,100
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$2,100

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$
- [Specialist copay](#) 7
- [Hospital \(facility\) copay](#) 5
- [Other coinsurance](#) 0
- [Specialist copay](#) \$80
- [Hospital \(facility\) copay](#) \$1,100
- [Other coinsurance](#) 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$750
Copayments	\$560
Coinsurance	\$0

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-816-395-2121.

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible
- Specialist coinsurance
- Hospital (facility) coinsurance

■ Other coinsurance

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	
Copayments	
Coinsurance	
<i>What isn't covered</i>	
Limits or exclusions	
The total Mia would pay is	

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, 816-395-6340 (local), 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, fax, 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
1-800-868-1019, 800-537-7697 (TDD)

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

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.