



⚠ 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/sgmoepo. 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 ?	\$2,750/Individual or \$5,500/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?	Yes, \$1,000/Individual or \$2,000/family for prescription drug expenses. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$5,000 individual / \$10,000 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	Visits 1-2 \$10 copay /office visit; Deductible does not apply. Visits 3+ 40% coinsurance /office visit	Not covered	Primary Care, Outpatient Mental Health and Outpatient Substance Abuse Office Visits are combined and count toward the 2 visits covered at the applicable copay . Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab).
	Specialist visit	40% coinsurance /office visit	Not covered	Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab).
	Preventive care/screening/immunization	No charge	Not covered	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)	40% coinsurance	Not covered	Blood Work: No charge if performed in preferred provider's office/independent lab after your office visit copay .
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BlueKC.com/MODL</p>	Generic drugs (Tier 1)	Basic Network \$10 copay /prescription / National Plus Network \$20 copay /prescription (retail) / \$25 copay /prescription (mail order); Deductible does not apply.	Not covered	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order). Generic Specialty (limited to 34-day supply) at retail. Basic Network \$20 copay /prescription / National Plus Network \$40 copay /prescription; Deductible does not apply.
	Preferred brand drugs (Tier 2)	Basic Network Prescription drug deductible then \$55 copay /prescription / National Plus Network \$80(retail) / \$137.50 copay /prescription (mail order)	Not covered	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order).
	Non-preferred brand drugs (Tier 3)	Basic Network Prescription drug deductible then 20% coinsurance /prescription / (retail) maximum \$250 / National Plus Network deductible then 30% coinsurance /prescription / (retail) maximum \$250 Prescription drug deductible then 20% coinsurance /prescription (mail order) maximum \$625	Not covered	Covers up to a 34-day supply (retail); between 34-102 day supply (mail order). Preferred Brand Specialty (limited to 34-day supply) at retail. Prescription drug deductible Basic Network 40% coinsurance /prescription maximum \$500; Deductible does not apply.
	Specialty drugs (Tier 4)	Basic Network Prescription drug deductible then 30% coinsurance /prescription (retail)	Not covered	Covers Non-Preferred Brand Specialty (limited to 30-day supply)

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)	
				Non-Preferred Brand Specialty (limited to 34-day supply) at retail. 50% coinsurance /prescription
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	None
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	40% coinsurance	Not covered	Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab).
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	Not covered	None
	Inpatient services	40% coinsurance	Not covered	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	40% coinsurance	Not covered	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).
	Childbirth/delivery professional services	40% coinsurance	Not covered	None
	Childbirth/delivery facility services	40% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	100 visits per calendar year maximum.
	Rehabilitation services	40% coinsurance	Not covered	Physical Therapy: 20 visit calendar year maximum; Occupational Therapy: 20 visit calendar year maximum; Speech and hearing

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)	
				therapy: unlimited visits; Pulmonary Therapy: 20 visit calendar year maximum; Cardiac Therapy: 36 visit calendar year maximum.
	Habilitation services	40% coinsurance	Not covered	Same limitations as Rehabilitation services.
	Skilled nursing care	40% coinsurance	Not covered	150 visits per 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	40% coinsurance	Not covered	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Hospice services	40% coinsurance	Not covered	Prior authorization is required for Inpatient hospice. Failure to obtain approval may result in the cost of the service being your responsibility.
If your child needs dental or eye care	Children's eye exam	\$25 copay /visit; Deductible does not apply	Not covered	Limited to one exam per calendar year. Limited to a child age 18 and younger.
	Children's glasses	No charge	Not covered	Limited to one pair of lenses/frames per calendar year. Limited to a child age 18 and younger.
	Children's dental check-up	No charge	Not covered	Routine oral exams 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 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)• Infertility treatment• 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• Hearing aids (limited to 1 every 3 years)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private-duty nursing (limited to 100 visits per calendar year)

Your Rights to Continue Coverage: If you have questions about your rights to continue your coverage, please call the customer service number on your ID card.

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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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 the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ 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:

Cost Sharing	
Deductibles	\$2,770
Copayments	\$0
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$150
The total Peg would pay is	\$4,720

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ 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:

Cost Sharing	
Deductibles*	\$3,420
Copayments	\$270
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$80
The total Joe would pay is	\$3,770

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,750
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	4
0%	
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles*	\$1,155
Copayments	\$0
Coinsurance	\$770

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.

Limits or exclusions	\$0	The total Mia would pay is	\$1,925
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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, 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>.

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 1-844-395-7126.

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[插入 SBM 項目的名稱 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 [在此插入數字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 اية 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 ສິດທິ ທ່ານຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນ ທ່ານສາມາດຂໍຮ້າງ ທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກບັນຍາຍພາສາ, 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. 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.