



 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/sgkshmo](http://www.bluekc.com/sgkshmo) or by calling 1-877-410-6716. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-410-6716 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, for non-grandfathered plans, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">Network providers</a> \$3,300 individual/ \$6,600 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.BlueKC.com">www.BlueKC.com</a> or call 1-877-410-6716 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> /scan	Not Covered	Only one <a href="#">copay</a> will apply for each provider on a specified date of service even if multiple scans are performed. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.BlueKC.com/dl">www.BlueKC.com/dl</a>	Generic drugs	\$12 <a href="#">copay</a> retail/\$25 <a href="#">copay</a> mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Includes Generic <a href="#">Specialty Drugs</a> .
	Preferred brand drugs	\$65 <a href="#">copay</a> retail/\$75 <a href="#">copay</a> mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Includes Non-Preferred Generic Drugs.
	Non-preferred brand drugs	\$90 <a href="#">copay</a> retail/\$125 <a href="#">copay</a> mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Includes Preferred Brand <a href="#">Specialty Drugs</a> .
	<a href="#">Specialty drugs</a>	\$250 <a href="#">copay</a>	Not Covered	Prescriptions for a <a href="#">specialty drug</a> will need to be filled at a designated specialty pharmacy. Limited to a one month supply. Includes only Non-Preferred Brand <a href="#">Specialty Drugs</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400 <u>copay</u> /day	Not Covered	Limited to a combined \$2,000 <u>copay</u> that includes inpatient hospital services and outpatient surgery in hospital or other outpatient facility; inpatient hospice; inpatient mental illness; and inpatient substance abuse per calendar year.
	Physician/surgeon fees	No Charge	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copay</u> waived if admitted to a hospital.
	<a href="#">Emergency medical transportation</a>	\$0 <u>copay</u> /use for ground ambulance	\$0 <u>copay</u> /use for ground ambulance	\$250 <u>copay</u> for air ambulance.
	<a href="#">Urgent care</a>	\$60 <u>copay</u> /visit	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400 <u>copay</u> /day	Not Covered	Limited to a combined \$2,000 <u>copay</u> that includes inpatient hospital services and outpatient surgery in hospital or other outpatient facility; inpatient hospice; inpatient mental illness; and inpatient substance abuse per 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 Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> /visit	Not Covered	None
	Inpatient services	400 <u>copay</u> /day	Not Covered	Limited to a combined \$2,000 <u>copay</u> that includes inpatient hospital services and outpatient surgery in hospital or other outpatient facility; inpatient hospice; inpatient mental illness; and inpatient substance abuse per calendar year. 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>	Office visits	\$60 <u>copay</u> /visit	Not Covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). You must pay your office visit <u>copayment</u> for each visit to a Physician for Complications of Pregnancy. Dependent daughters are not covered for maternity services. Only one office visit <u>copayment</u> shall apply for Physician obstetrical services per pregnancy.
	Childbirth/delivery professional services	No charge	Not Covered	Dependent daughters are not covered for maternity services.
	Childbirth/delivery facility services	\$400 <u>copay</u> /day	Not Covered	Dependent daughters are not covered for maternity services. Limited to \$2,000 <u>copay</u> per calendar year.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30 <u>copay</u> / visit	Not Covered	60 visit calendar year maximum.
	<a href="#">Rehabilitation services</a>	No Charge	Not Covered	Physical, occupational and skeletal manipulation: 60 combined visit calendar year maximum. Speech and hearing: 20 visit calendar year maximum.

\* For more information about limitations and exceptions, see the plan or policy document at [www.BlueKC.com](http://www.BlueKC.com)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	No Charge	Not Covered	None
	<a href="#">Skilled nursing care</a>	\$60 <u>copay</u> /day	Not Covered	Limited to \$300 <u>copay</u> per calendar year. 30 day calendar year maximum. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	<a href="#">Hospice services</a>	\$200 <u>copay</u> /day	Not Covered	Limited to a combined \$2,000 <u>copay</u> that includes inpatient hospital services and outpatient surgery in hospital or other outpatient facility; inpatient hospice; inpatient mental illness; and inpatient substance abuse per calendar year. 14 day lifetime maximum at an inpatient hospice facility. Prior authorization is required for service 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>	Children's eye exam	\$20 <u>copay</u>	Not Covered	Limited to one eye exam per calendar year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.BlueKC.com](http://www.BlueKC.com)

## 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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care limited to a combined (PT/OT/Skeletal manipulation) 60 visit calendar year maximum
- Private-duty nursing
- Routine eye care limited to one eye exam per calendar year

**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: Blue Cross and Blue Shield of Kansas City at 816-395-2953 or [www.BlueKC.com](http://www.BlueKC.com), 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), Healthcare.gov at [www.Healthcare.gov](http://www.Healthcare.gov) or call 1-800-318-2596. 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](http://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: 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), 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, 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](#) \$0
- [Specialist](#) Copayment \$60
- [Hospital \(facility\)](#) Copayment \$400
- 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$960
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,020</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) Copayment \$60
- [Hospital \(facility\)](#) Copayment \$400
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,730
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$2,760</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) Copayment \$60
- [Hospital \(facility\)](#) Copayment \$400
- 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$240
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$240</b>

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.



## 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 1-844-395-7126.

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 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.



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.

