




**⚠** 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/sgmoppo](http://www.BlueKC.com/sgmoppo). 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](http://www.BlueKC.com/Glossary) or call 1-877-410-6716 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$5,000 / Individual or \$10,000 / family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some 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, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$6,500/individual or \$13,000/ family; for <a href="#">out-of-network providers</a> \$13,000/individual or \$26,000 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-billing</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 <a href="#">referral</a> .

 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)	
<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	Visits 1-4 \$10 <a href="#">copay</a> /office visit; <a href="#">Deductible</a> does not apply Visits 5+ No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Primary Care, Specialist, Urgent Care, and Outpatient Mental Illness/Substance Abuse Office Visits are combined and count toward the 4 visits covered at the applicable <a href="#">copay</a> per Calendar Year.
	<a href="#">Specialist</a> visit	Visits 1-4 \$10 <a href="#">copay</a> /office visit; <a href="#">Deductible</a> does not apply Visits 5+ No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Primary Care, Specialist, Urgent Care, and Outpatient Mental Illness/Substance Abuse Office Visits are combined and count toward the 4 visits covered at the applicable <a href="#">copay</a> per Calendar Year.
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . 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 after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Blood Work: No charge if performed in preferred provider's office/independent lab after your office visit <a href="#">copay</a> .
	Imaging (CT/PET scans, MRIs)	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	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><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/MODL">www.BlueKC.com/MODL</a></p>	Generic drugs (Tier 1)	National Plus Network \$10 <a href="#">copay</a> /prescription (retail) / \$25 <a href="#">copay</a> /prescription (mail order).  <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> (retail & mail order).	Covers up to a 34-day supply (retail); between 35-102 day supply (mail order).  Generic Specialty drugs (limited to 30-day supply) at Accredo Specialty Pharmacy \$10 <a href="#">copay</a> / prescription.  Generic Specialty drugs (limited to 30-day supply) at National Plus Network (retail) \$20 <a href="#">copay</a> / prescription.  <a href="#">Deductible</a> does not apply.
	Preferred brand drugs (Tier 2)	National Plus Network \$55 <a href="#">copay</a> / prescription (retail) \$137.50 <a href="#">copay</a> / prescription (mail order).  <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> (retail & mail order).	Covers up to a 34-day supply (retail); between 35-102 day supply (mail order).
	Non-preferred brand drugs (Tier 3)	National Plus Network 20% <a href="#">coinsurance</a> / prescription (retail) maximum \$250 / 20% <a href="#">coinsurance</a> / prescription (mail order) maximum \$625.  <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> (retail & mail order).	Covers up to a 34-day supply (retail); between 35-102 day supply (mail order).  Preferred Brand Specialty drugs (limited to 30-day supply) at Accredo Specialty Pharmacy 20% <a href="#">coinsurance</a> / prescription maximum \$250.  Preferred Brand Specialty drugs (limited to 30-day supply) at National Plus Network (retail) 40% <a href="#">coinsurance</a> / prescription maximum \$500.  <a href="#">Deductible</a> does not apply.
	<a href="#">Specialty drugs</a> (Tier 4)	National Plus Network 50% <a href="#">coinsurance</a> /	50% <a href="#">coinsurance</a> (retail).	Covers Non-Preferred Brand Specialty drugs (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)	
		prescription (retail).		Non-Preferred Brand Specialty drugs (limited to 30-day supply) at Accredo Specialty Pharmacy 30% <a href="#">coinsurance</a> / prescription.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Prior authorization is required for certain services. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fees	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	No charge after <a href="#">deductible</a>	No charge after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	Visits 1-4 \$10 <a href="#">copay</a> /office visit; <a href="#">Deductible</a> does not apply Visits 5+ No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Primary Care, Specialist, Urgent Care, and Outpatient Mental Illness/Substance Abuse Office Visits are combined and count toward the 4 visits covered at the applicable <a href="#">copay</a> per Calendar Year.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fees	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	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	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

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)	
	Childbirth/delivery professional services	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	100 visits per calendar year maximum.
	<a href="#">Rehabilitation services</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	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.
	<a href="#">Habilitation services</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Same limitations as <a href="#">Rehabilitation services</a> .
	<a href="#">Skilled nursing care</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	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.
	<a href="#">Durable medical equipment</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	<a href="#">Hospice services</a>	No charge after <a href="#">deductible</a>	20% <a href="#">coinsurance</a>	Prior authorization is required. 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	\$25 <a href="#">copay</a> /visit; <a href="#">Deductible</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids (limited to 1 every 3 years)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing (limited to 100 visits per calendar year)</li></ul>

**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), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 [www.cciio.cms.gov](http://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](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: 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](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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,260</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$100
Copayments	\$3,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,160</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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>
---------------------------	----------------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1,600
Copayments	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,630</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.

## **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.



