



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/dpmoppo 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 or call 1-877-410-6716 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$2,500 individual / \$7,500 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 services 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. |
| What is the out-of-pocket limit for this plan? | For In-Network providers \$4,500 individual / \$13,500 family. For Out-of-Network providers \$9,000 individual / \$27,000 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 in-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 in-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 the 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 |
|---|--|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network 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 - 5: \$30 copay /visit, Deductible does not apply Visits 6+: No charge | 40% coinsurance , Deductible does not apply | Primary Care, Specialist , Urgent Care, and Outpatient Mental Illness/Substance Abuse Office Visits are combined and count toward the 5 visits covered at the applicable copay per Calendar Year. Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab). |
| | Specialist visit | Visits 1 - 5: \$30 copay /visit, Deductible does not apply Visits 6+: No charge | 40% coinsurance | Same limitations as primary care. |
| | Preventive care/screening/immunization | No charge, Deductible does not apply | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Blood Work: No charge if performed in In-Network provider's office/independent lab. Diagnostic services performed at a Non-Participating Imaging Center inside our Service Area are limited to \$200 per Day. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% 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 |
|---|--|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BlueKC.com/modl | Generic drugs, including Specialty drugs | RxPremier: Retail \$12 copay /fill; Mail Order \$36 copay /fill | Retail \$12 copay /fill, then 50% coinsurance ; Mail Order \$36 copay /fill, then 50% coinsurance | Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply. |
| | Preferred brand drugs, including Specialty drugs | Not covered | Not covered | None |
| | Non-preferred brand drugs, including Specialty drugs | Not covered | Not covered | None |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Certain outpatient surgeries and services must be prior authorized. Failure to obtain approval may result in the cost of the service being your responsibility. Outpatient services performed in a Non-Participating Provider Hospital or in a Non-Participating outpatient facility (including an imaging center) inside our Service Area are limited to \$200 per Day. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance after In- Network Deductible | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance after In- Network Deductible | None |
| | Urgent care | Visits 1 - 5: \$30 copay /visit, Deductible does not apply Visits 6+: No charge | 40% coinsurance | Same limitations as primary care. |

| 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) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Inpatient hospital services performed in a Non-Participating Provider Hospital inside our Service Area are limited to \$200 per Day. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit: Visits 1 - 5: \$30 copay /visit, Deductible does not apply Visits 6+: No charge; Therapy in a Provider's Office: 20% coinsurance ; Therapy in a Facility: | Office Visit: 40% coinsurance ; Therapy in a Provider's Office: 40% coinsurance ; Therapy in a Facility: Not covered | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Inpatient services performed in a Non-Participating Provider Hospital inside our Service Area are limited to \$200 per Day. 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 | Not covered | Not covered | None |
| | Childbirth/delivery professional services | Not covered | Not covered | None |
| | Childbirth/delivery facility services | Not covered | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | 60 visit Calendar Year maximum. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Physical and occupational: 40 combined visit Calendar Year maximum. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | 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) | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 30 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 | 20% coinsurance | 40% coinsurance | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Hospice services | 20% coinsurance | 40% coinsurance | 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. |
| If your child needs dental or eye care | Children's eye exam | \$20 copay /visit, Deductible does not apply | \$20 copay /visit, Deductible does not apply | Limited to one eye exam per Calendar Year. Out-of- Network limited to \$45 Benefit Max per Calendar Year. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | 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 .) | | |
|---|---------------------|-------------------------|
| • Acupuncture | • Bariatric surgery | • Cosmetic surgery |
| • Dental care | • Hearing aids | • Infertility treatment |
| • Long-term care | • 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
- Non-emergency care when traveling outside the U.S.
- 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, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>, Healthcare.gov at 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 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](#).

—————*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 | \$2,500 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,500 |
| Copayments | \$40 |
| Coinsurance | \$1,800 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,400 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$3,600 |
| The total Joe would pay is | \$5,300 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,500 |
| ■ Specialist copayment | \$30 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,600 |
| Copayments | \$60 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,660 |

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.

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, 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: 가 [Blue KC] 1-877-410-6716 가 .

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 تساعد 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: ຖ້າ ທ່ານ, ຫຼື ຄົນ ທ່ານ ກຳ ລັງ ຊ່ວຍ ຫຼື ອ, ມີ ຄຳ ຖາມ ກ່ຽວ ກັບ Blue KC, ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຊ່ວຍ ຫຼື ອ ແລະ ຂໍ້ ມູ ນ ຂ່າວ ສານ ທີ່ ບໍ່ ມີ ພາ ສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ຈ້ ຈ່ ຈາຍ. ການ ໂອ້ ວິ ມ ກັບ ນາຍ ພາ ສາ, ໃຫ້ ໂທ ຫາ 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.



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