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.	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?	Yes. For prescription drug services: $500 individual / Not applicable family. 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?	For In-Network providers $4,500. For Out-of-Network providers $9,000.	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: $40 copay/visit, Deductible does not apply Visits 6+: 20% coinsurance	Visits 1 - 5: 40% coinsurance, Deductible does not apply Visits 6+: 40% coinsurance	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: $40 copay/visit, Deductible does not apply Visits 6+: 20% coinsurance	Visits 1 - 5: 40% coinsurance, Deductible does not apply Visits 6+: 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, Deductible does not apply; Mail Order $36 copay/fill, Deductible does not apply	Retail $12 copay/fill, then 50% coinsurance, Deductible does not apply; Mail Order $36 copay/fill, then 50% coinsurance, Deductible does not apply	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	RxPremier: Retail 50% coinsurance; Mail Order 50% coinsurance	Retail $50 copay/fill, then Deductible, then 50% coinsurance; Mail Order $150 copay/fill, then Deductible, 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.
	Non-preferred brand drugs, including Specialty drugs	RxPremier: Retail 50% coinsurance; Mail Order 50% coinsurance	Retail $80 copay/fill, then 50% coinsurance, Deductible does not apply; Mail Order $240 copay/fill, then 50% coinsurance, Deductible does not apply	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.
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

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)	
	Urgent care	Visits 1 - 5: $40 copay/visit, Deductible does not apply Visits 6+: 20% coinsurance	Visits 1 - 5: 40% coinsurance, Deductible does not apply Visits 6+: 40% coinsurance	Same limitations as primary care.
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: $40 copay/visit, Deductible does not apply Visits 6+: 20% coinsurance; Therapy in a Provider's Office: 20% coinsurance; Therapy in a Facility: 20% coinsurance	40% coinsurance	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.

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)	
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical and occupational: 40 combined visit Calendar Year maximum.
	Habilitation services	20% coinsurance	40% coinsurance	None
	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	$40
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	$40
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*	$1,500
Copayments	$800
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$3,830**

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

The plan's overall deductible	$2,500
Specialist copayment	$40
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	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,680**

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.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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: **만약 귀하 또는 귀하가 돕고 있는 어떤 사람이** [Blue KC]**에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 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 تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ1-877-410-6716.

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 ທ່ ານ, ຫຼື ຄົນ ່ທທ່ ານກ ່ າລັງຊ ່ ວຍເຫຼື ອ, ມ ່ ຄ ວ າ ມ ກ ່ ຽ ວ ກ ັ ບ Blue KC, ທ ່ ານ ມ ີ ສ ດ ່ ທ ຈ ະ ໄ ດ ້ ຮ ັ ບ ການຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ແ ລ ະ ່ ຂ ໍ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ່ ທ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ່ ບ ມ ຄ ່ າ ໃ ຊ ້ จ ่ าย. ການໂອ້ ລົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ້ ໂ ທ ຫ າ 1-877-410-6716.

Pennsylvanian Dutch: “Wann du hoscht en Froog, odder ebber, wu du helfscht, 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 کمکو اطلاعات به زبان خود را به طور رایگان دریافت نمایید .تماس حاصل نمایید 1-877-410-6716

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.

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association