



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/ksppo](http://www.bluekc.com/ksppo) 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> ?                                | \$2,000 individual / \$4,000 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> services 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">In-Network providers</a> \$4,000 individual / \$8,000 family. For <a href="#">Out-of-Network providers</a> \$20,000 individual / \$40,000 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="#">in-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="#">in-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                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                                 | 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                | \$40 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply.                          | 50% <a href="#">coinsurance</a>                                                                                                                                      | Other services/procedures that are performed in a physician's office are subject to the <a href="#">network deductible</a> and <a href="#">coinsurance</a> level (excluding lab).                                                   |
|                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                                | \$40 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply.                          | 50% <a href="#">coinsurance</a>                                                                                                                                      | Same limitations as primary care.                                                                                                                                                                                                   |
|                                                                                                                                                                                                           | <a href="#">Preventive care/screening/immunization</a>          | No charge, <a href="#">Deductible</a> does not apply.                                                  | 50% <a href="#">coinsurance</a>                                                                                                                                      | 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)             | 20% <a href="#">coinsurance</a>                                                                        | 50% <a href="#">coinsurance</a>                                                                                                                                      | Blood Work: No charge if performed in <a href="#">In-Network provider's</a> office/independent lab.                                                                                                                                 |
|                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                                    | 20% <a href="#">coinsurance</a>                                                                        | 50% <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 need drugs to treat your illness or condition</b><br>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, including Specialty, drugs                             | National Plus: Retail \$15 <a href="#">copay</a> /fill; Mail Order \$37.50 <a href="#">copay</a> /fill | Retail \$15 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a> ; Mail Order \$37.50 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a> | Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Prescriptions for a <a href="#">specialty drug</a> will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply. |
|                                                                                                                                                                                                           | Preferred brand drugs                                           | National Plus: Retail \$70 <a href="#">copay</a> /fill; Mail Order \$175 <a href="#">copay</a> /fill   | Retail \$70 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a> ; Mail Order \$175 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a>   | Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order).                                                                                                                                                  |
|                                                                                                                                                                                                           | Non-preferred brand, including Preferred brand Specialty, drugs | National Plus: Retail \$110 <a href="#">copay</a> /fill; Mail Order \$275 <a href="#">copay</a> /fill  | Retail \$110 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a> ; Mail Order \$275 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a>  | Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). Prescriptions for a <a href="#">specialty drug</a> will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply. |
|                                                                                                                                                                                                           | Non-preferred brand <a href="#">Specialty drugs</a>             | National Plus: Retail \$200 <a href="#">copay</a> /fill                                                | Retail \$200 <a href="#">copay</a> /fill, then 50% <a href="#">coinsurance</a>                                                                                       | Prescriptions for a <a href="#">specialty drug</a> will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply.                                                                                    |

| 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 outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                        | 50% <a href="#">coinsurance</a>                                                                                       | Certain outpatient surgeries and services must be prior authorized. Failure to obtain approval may result in the cost of the service being your responsibility.                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                        | 50% <a href="#">coinsurance</a>                                                                                       | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$100 <a href="#">copay</a> /visit, then <a href="#">deductible</a> , then 20% <a href="#">coinsurance</a>                             | \$100 <a href="#">copay</a> /visit, then <a href="#">In-Network deductible</a> , then 20% <a href="#">coinsurance</a> | <a href="#">Copay</a> waived if admitted to a hospital.                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                        | 20% <a href="#">coinsurance</a>                                                                                       | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply.                                                          | 50% <a href="#">coinsurance</a>                                                                                       | Same limitations as primary care.                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                        | 50% <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                           | 20% <a href="#">coinsurance</a>                                                                                                        | 50% <a href="#">coinsurance</a>                                                                                       | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit: \$40 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply. ; Therapy: 20% <a href="#">coinsurance</a> | 50% <a href="#">coinsurance</a>                                                                                       | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                                        | 50% <a href="#">coinsurance</a>                                                                                       | 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 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply.                                                          | 50% <a href="#">coinsurance</a>                                                                                       | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).<br>You must pay your office visit <a href="#">copayment</a> for each visit to a Physician for Complications of Pregnancy. Only one office visit <a href="#">copayment</a> shall apply for Physician obstetrical services per pregnancy.<br>Dependent daughters are not covered for maternity services. |

| 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)                              |                                                                                                                                                                                                                                         |
|                                                                       | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | Dependent daughters are not covered for maternity services.                                                                                                                                                                             |
|                                                                       | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | Dependent daughters are not covered for maternity services.                                                                                                                                                                             |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | 60 visit Calendar Year maximum.                                                                                                                                                                                                         |
|                                                                       | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | Physical, occupational, and skeletal manipulation: 60 combined visit Calendar Year maximum.<br>Speech and hearing: 20 combined visit Calendar Year maximum.                                                                             |
|                                                                       | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | None                                                                                                                                                                                                                                    |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | 30 day Calendar Year maximum.<br>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> | 20% <a href="#">coinsurance</a>                                               | 50% <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>          | 20% <a href="#">coinsurance</a>                                               | 50% <a href="#">coinsurance</a>                                              | 14 day Lifetime maximum at an inpatient hospice facility.<br>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 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply. | \$20 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply | Limited to one eye exam per Calendar Year.<br>Out-of- <a href="#">Network</a> 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
- Dental care (Adult)
- Long-term care
- Bariatric surgery
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Infertility treatment
- 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
- Routine eye care (Adult) limited to one eye exam per Calendar Year
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

**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), 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: 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](#).

—————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> | \$2,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,000        |
| Copayments                        | \$40           |
| Coinsurance                       | \$1,900        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,000</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> | \$2,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$1,800        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$30           |
| <b>The total Joe would pay is</b> | <b>\$2,830</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> | \$2,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,600        |
| Copayments                        | \$80           |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,680</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.

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 ກຳລັງ ຊ່ວຍ ຫຼື ອ, ມີ ຄຳ ຖາມ ກ່ຽວ ກັບ Blue KC, ທ່ານ ມີ ສິດ ທີ່ ຈະ ໄດ້ ຮັບ ການ ຊ່ວຍ ຫຼື ອ ລະ ດັ່ງ ມູນ ຂ່າວ ສານ ທ່ານ ບໍ່ ພາ ສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ຈ້າ ຈ່າ ຈາຍ. ການ ໂອ້ ວິ ມັ ກັ ບ ນ າ ຍ 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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