This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BlueKC.com or by calling 1-877-410-6716.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For **preferred providers** **$4,000** person / **$10,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	**Premiums**, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.BlueKC.com **or call 1-877-410-6716** for a list of **preferred providers.**	If you use a **preferred** doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your **preferred** doctor or hospital may use a **non-preferred provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not Covered	——————none——————
	Specialist visit	$50 copay/visit	Not Covered	——————none——————
	Other practitioner office visit	$50 copay/visit for Chiropractor	Not Covered	Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$200 copay/scan	Not Covered	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BlueKC.com.	Generic drugs	$15 copay retail/$30 copay mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order)
	Preferred brand drugs	$40 copay retail/$80 copay mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order)
	Non-preferred brand drugs	$60 copay retail/$120 copay mail order	Not Covered	Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order)

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
	Specialty drugs	Same cost sharing as retail.	Not Covered	Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy. Limited to a one month supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay /day	Not Covered	Limited to $1500 copay per calendar year.
	Physician/surgeon fees	No Charge	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit	Copay waived if admitted to a hospital.
	Emergency medical transportation	$0 copay/use for ground ambulance	$0 copay/use for ground ambulance	————————none————————
	Urgent care	$50 copay /visit	Not Covered	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay /day	Not Covered	Limited to $1500 copay per calendar year. Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility
	Physician/surgeon fee	No Charge	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay /visit	Not Covered	Your employer participates in an employee assistance program. This program may provide additional mental health or substance abuse benefits.
	Mental/Behavioral health inpatient services	$300 copay /day	Not Covered	Limited to $1500 copay per calendar year. Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility
	Substance use disorder outpatient services	$25 copay /visit	Not Covered	————————none————————
	Substance use disorder inpatient services	$300 copay /day	Not Covered	Limited to $1500 copay per calendar year. Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility
If you are pregnant	Prenatal and postnatal care	No charge	Not Covered	Dependent daughters are not covered for maternity services.
	Delivery and all inpatient services	$300 copay /day	Not Covered	Dependent daughters are not covered for maternity services. Limited to $1500 copay per calendar year.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	60 visit calendar year maximum.
	Rehabilitation services	No Charge	Not Covered	Physical, occupational and skeletal manipulation: 40 combined visit calendar year maximum. Speech and hearing 20 visit calendar year maximum.
	Habilitation services	No Charge	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	30 day calendar year maximum. Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility
	Durable medical equipment	No Charge	Not Covered	Prior authorization is required. Failure to obtain approval, results in the cost of the service being your responsibility.
	Hospice service	$150 copay / day	Not Covered	Limited to the inpatient/outpatient hospital copay maximum. 14 day lifetime maximum at an inpatient hospice facility. Prior authorization is required for service received at an inpatient facility. Failure to obtain approval, results in the cost of the service being your responsibility
If your child needs dental or eye care	Eye exam	$10 copay	Not Covered	Limited to one eye exam per calendar year.
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses
- Hearing aids (Age 1 and over)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care limited to a combined (PT/OT/Skeletal manipulation) 40 visit calendar year maximum
- Private-duty nursing
- Routine eye care limited to one eye exam per calendar year

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-989-8842. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Missouri Department of Insurance at 1-800-726-7390 or the Kansas Department of Insurance at 1-800-432-2484. If your group health plan is subject to ERISA, you may also contact the Employee Benefits Security Administration for assistance at 1-866-444-3272. Additionally, a consumer assistance program can help you file your appeal. Contact your insurance department for more information.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-410-6716.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-410-6716.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-410-6716.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-410-6716.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7540
- **Plan pays** $7040
- **Patient pays** $500

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**

Patient pays:

Deductibles	$0
Co-pays	$300
Co-insurance	$0
Limits or exclusions	$200
Total	**$500**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact 1-877-410-6716.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan pays** $4260
- **Patient pays** $1140

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**

Patient pays:

Deductibles	$0
Co-pays	$1100
Co-insurance	$0
Limits or exclusions	$40
Total	**$1140**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 1-866-859-3813.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from preferred **providers**. If the patient had received care from non-preferred **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.