

 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/ksepo](http://www.bluekc.com/ksepo) 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-877-410-6716 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0 individual / \$0 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?              | Yes. For <a href="#">prescription drug</a> services: \$200 individual / \$400 family. There are no other specific <a href="#">deductibles</a> .      | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,000 individual / \$10,000 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/epo/bsp">www.BlueKC.com/epo/bsp</a> or call 1-877-410-6716 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                                        | Services You May Need                                                | What You Will Pay                                                                                                                                                   |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                             |                                                                      | In-Network Provider<br>(You will pay the least)                                                                                                                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                  |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                               | Primary care visit to treat an injury or illness                     | \$35 <a href="#">copay</a> /visit                                                                                                                                   | Not covered                                        | 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                                     | \$70 <a href="#">copay</a> /visit                                                                                                                                   | Not covered                                        | Same limitations as primary care.                                                                                                                                                                                                |
|                                                                                                                                                                                                                             | <a href="#">Preventive care/screening/immunization</a>               | No charge                                                                                                                                                           | Not covered                                        | 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)                  | No charge                                                                                                                                                           | Not covered                                        | Blood Work: No charge if performed in In- <a href="#">Network provider</a> 's office/independent lab.                                                                                                                            |
|                                                                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                                         | \$250 <a href="#">copay/provider</a> per day                                                                                                                        | Not covered                                        | <a href="#">Prior authorization</a> 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/2027Premium">www.bluekc.com/2027Premium</a> | Generic drugs, including <a href="#">Specialty drugs</a>             | RxPremier: Retail <a href="#">Deductible</a> then \$12 <a href="#">copay</a> /fill;<br>Mail Order <a href="#">Deductible</a> then \$24 <a href="#">copay</a> /fill  | Not covered                                        | <a href="#">Prior authorization</a> may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). |
|                                                                                                                                                                                                                             | Preferred brand drugs, including <a href="#">Specialty drugs</a>     | RxPremier: Retail <a href="#">Deductible</a> then \$60 <a href="#">copay</a> /fill;<br>Mail Order <a href="#">Deductible</a> then \$120 <a href="#">copay</a> /fill | Not covered                                        | <a href="#">Prior authorization</a> may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). |
|                                                                                                                                                                                                                             | Non-preferred brand drugs, including <a href="#">Specialty drugs</a> | RxPremier: Retail <a href="#">Deductible</a> then \$80 <a href="#">copay</a> /fill;<br>Mail Order <a href="#">Deductible</a> then \$160 <a href="#">copay</a> /fill | Not covered                                        | <a href="#">Prior authorization</a> may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to 34 day supply (retail) and between 35 to 102 day supply (mail order). |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                                                                                                                                                          |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | \$600 <a href="#">copay</a> /day                                                                                                                                           | Not covered                                        | Certain outpatient surgeries and services must be prior authorized. Failure to obtain approval may result in the cost of the service being your responsibility.<br>Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, Inpatient Hospice, Outpatient Surgery and Maternity Services. <a href="#">copayments</a> are combined and count toward a \$3,000 Maximum per Calendar Year in BlueSelect Plus. |
|                                                                                  | Physician/surgeon fees                           | No charge                                                                                                                                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | \$250 <a href="#">copay</a> /visit                                                                                                                                         | \$250 <a href="#">copay</a> /visit                 | <a href="#">Copay</a> waived if admitted to a hospital.                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                  | <a href="#">Emergency medical transportation</a> | No charge                                                                                                                                                                  | No charge                                          | None                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | <a href="#">Urgent care</a>                      | \$70 <a href="#">copay</a> /visit                                                                                                                                          | \$70 <a href="#">copay</a> /visit                  | Same limitations as primary care.                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | \$600 <a href="#">copay</a> /day                                                                                                                                           | Not covered                                        | Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, Inpatient Hospice, Outpatient Surgery and Maternity Services. <a href="#">copayments</a> are combined and count toward a \$3,000 Maximum per Calendar Year in BlueSelect Plus. <a href="#">Prior authorization</a> is required. Failure to obtain approval may result in the cost of the service being your responsibility.                       |
|                                                                                  | Physician/surgeon fees                           | No charge                                                                                                                                                                  | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | Office Visit: \$15 <a href="#">copay</a> /visit;<br>Therapy in a <a href="#">Provider's</a> Office: \$15 <a href="#">copay</a> /visit;<br>Therapy in a Facility: No charge | Not covered                                        | Your employer participates in an employee assistance program. This program may provide additional mental health or substance abuse benefits.                                                                                                                                                                                                                                                                               |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | Inpatient services                        | \$600 <a href="#">copay</a> /day                | Not covered                                        | Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, Inpatient Hospice, Outpatient Surgery and Maternity Services. <a href="#">copayments</a> are combined and count toward a \$3,000 Maximum per Calendar Year in BlueSelect Plus. <a href="#">Prior authorization</a> is required. Failure to obtain approval may result in the cost of the service being your responsibility.                                                                                                     |
| If you are pregnant                                            | Office visits                             | \$70 <a href="#">copay</a> /visit               | Not covered                                        | <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). You must pay your office visit <a href="#">copayment</a> for each visit to a Physician for <a href="#">Complications of Pregnancy</a> . Only one office visit <a href="#">copayment</a> shall apply for Physician obstetrical services per pregnancy. Dependent daughters are not covered for maternity services. |
|                                                                | Childbirth/delivery professional services | No charge                                       | Not covered                                        | Dependent daughters are not covered for maternity services.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | Childbirth/delivery facility services     | \$600 <a href="#">copay</a> /day                | Not covered                                        | Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, Inpatient Hospice, Outpatient Surgery and Maternity Services. <a href="#">copayments</a> are combined and count toward a \$3,000 Maximum per Calendar Year in BlueSelect Plus. Dependent daughters are not covered for maternity services.                                                                                                                                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | \$35 <a href="#">copay</a> /visit               | Not covered                                        | 60 visit Calendar Year maximum.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                                |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | In-Network Provider<br>(You will pay the least)                                                  | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                        | <a href="#">Rehabilitation services</a>   | Physical Therapy: \$35 <a href="#">copay</a> /visit; See member certificate for other therapies. | Not covered                                        | Physical, occupational, and skeletal manipulation: 60 combined visit Calendar Year maximum. Speech and hearing: 20 combined visit Calendar Year maximum.                                                                                                                                                                                                                                                                                                                                                     |
|                                        | <a href="#">Habilitation services</a>     | Physical Therapy: \$35 <a href="#">copay</a> /visit; See member certificate for other therapies. | Not covered                                        | See Rehabilitation Service Limits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                        | <a href="#">Skilled nursing care</a>      | \$70 <a href="#">copay</a> /day                                                                  | Not covered                                        | 30 day Calendar Year maximum. <a href="#">Prior authorization</a> is required. Failure to obtain approval may result in the cost of the service being your responsibility.                                                                                                                                                                                                                                                                                                                                   |
|                                        | <a href="#">Durable medical equipment</a> | No charge                                                                                        | Not covered                                        | <a href="#">Prior authorization</a> is required. Failure to obtain approval may result in the cost of the service being your responsibility.                                                                                                                                                                                                                                                                                                                                                                 |
|                                        | <a href="#">Hospice services</a>          | \$300 <a href="#">copay</a> /day                                                                 | Not covered                                        | Inpatient Hospital, Inpatient Mental Illness, Inpatient Substance Abuse, Inpatient Hospice, Outpatient Surgery and Maternity Services. <a href="#">copayments</a> are combined and count toward a \$3,000 Maximum per Calendar Year in BlueSelect Plus. 14 day Lifetime maximum at an inpatient hospice facility. <a href="#">Prior authorization</a> 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                       | \$10 <a href="#">copay</a> /visit                                                                | Not covered                                        | Limited to one eye exam 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](#).)

- Abortion (except when the life of the mother is endangered)
- Cosmetic surgery
- Long-term care
- Acupuncture
- Dental care
- Routine foot care
- Bariatric surgery
- Hearing aids

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Private-duty nursing
- Coverage provided outside the United States. See [www.bluekc.com/ksepo](http://www.bluekc.com/ksepo).
- Routine eye care limited to one eye exam per Calendar Year
- Infertility treatment
- Weight loss programs

**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), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), Church [plans](#) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how 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, the Kansas Department of Insurance at 800-432-2484 or at [www.insurance.kansas.gov](http://www.insurance.kansas.gov), the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa).

### Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$70  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing                 |         |
|------------------------------|---------|
| <a href="#">Deductibles*</a> | \$10    |
| <a href="#">Copayments</a>   | \$1,300 |
| <a href="#">Coinsurance</a>  | \$0     |
| What isn't covered           |         |
| Limits or exclusions         | \$60    |
| The total Peg would pay is   | \$1,370 |

**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> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$70  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing                 |         |
|------------------------------|---------|
| <a href="#">Deductibles*</a> | \$200   |
| <a href="#">Copayments</a>   | \$1,400 |
| <a href="#">Coinsurance</a>  | \$0     |
| What isn't covered           |         |
| Limits or exclusions         | \$0     |
| The total Joe would pay is   | \$1,600 |

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

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$70  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">coinsurance</a>                             | 0%    |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing                 |       |
|------------------------------|-------|
| <a href="#">Deductibles*</a> | \$10  |
| <a href="#">Copayments</a>   | \$500 |
| <a href="#">Coinsurance</a>  | \$0   |
| What isn't covered           |       |
| Limits or exclusions         | \$0   |
| The total Mia would pay is   | \$510 |

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

## Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City (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.

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 1-877-395-7126.

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 1-844-395-7126.

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).

