

 **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, BlueKC.Com or by calling 1-877-410-6716. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-877-410-6716 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | \$6,500 individual / \$13,000 family. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. Preventive care services are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$8,000 individual / \$16,000 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization for services may be incurred, which can result in the cost of the service being your responsibility. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.BlueKC.com/qhp/pcb or call 1-877-410-6716 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |



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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 50% coinsurance | Not covered | None |
| | Specialist visit | 50% coinsurance | Not covered | None |
| | Preventive care/screening/immunization | No charge, Deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 50% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | Not covered | Prior authorization is required. Failure to obtain approval may result 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/2024IFPSGACAKS | Generic drugs | 50% coinsurance | Not covered | Prior authorization may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to a 34 day supply. |
| | Preferred brand drugs | 50% coinsurance | Not covered | Prior authorization may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to a 34 day supply. |
| | Non-preferred brand drugs | 50% coinsurance | Not covered | Prior authorization may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up to a 34 day supply. |
| | Specialty drugs | 50% coinsurance | Not covered | Prior authorization may be required. Failure to obtain approval may result in the cost of the drug being your responsibility. Covers up 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) | 50% coinsurance | 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. |
| | Physician/surgeon fees | 50% coinsurance | Not covered | None |
| If you need immediate medical attention | Emergency room care | 50% coinsurance | 50% coinsurance after In- Network Deductible | None |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance after In- Network Deductible | None |
| | Urgent care | 50% coinsurance | 50% coinsurance after In- Network Deductible | Same limitations as primary care. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Physician/surgeon fees | 50% coinsurance | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 50% coinsurance | Not covered | None |
| | Inpatient services | 50% coinsurance | Not covered | 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 | 50% coinsurance | Not covered | Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 50% coinsurance | Not covered | None |
| | Childbirth/delivery facility services | 50% coinsurance | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | 50% coinsurance | Not covered | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | 50% coinsurance | Not covered | Speech: 90 visit Calendar Year maximum. |
| | Habilitation services | 50% coinsurance | Not covered | None |
| | Skilled nursing care | Not covered | Not covered | None |
| | Durable medical equipment | 50% coinsurance | Not covered | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Hospice services | 50% coinsurance | Not covered | Prior authorization is required for service received at an inpatient facility. Failure to obtain approval may result in the cost of the service being your responsibility. |
| If your child needs dental or eye care | Children's eye exam | No charge, Deductible does not apply | Not covered | Limited to a child age 18 and younger. |
| | Children's glasses | 50% coinsurance | Not covered | Limited to 3 Pair of Lenses and 3 Frame(s) per Calendar Year for In- Network maximum. Limited to a child age 18 and younger. |
| | 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
- Routine foot care (except for certain conditions)
- Acupuncture
- Dental care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Bariatric surgery
- Hearing aids
- Routine eye care (Adult)

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

- Infertility treatment
- Private-duty nursing
- Spinal manipulation included under Rehabilitation services

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, the Kansas Insurance Department at 800-432-2484 or at www.insurance.kansas.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the

[Marketplace](#), visit www.HealthCare.gov or call 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: Kansas Insurance Department at 800-432-2484 or at www.insurance.kansas.gov.

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? Not applicable.

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.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$6,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$6,500 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$8,060 |

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$5,200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$5,200 |

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

- The [plan's](#) overall [deductible](#) \$6,500
- [Specialist coinsurance](#) 50%
- Hospital (facility) [coinsurance](#) 50%
- Other [coinsurance](#) 50%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |

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