

 **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.bluekcforyou.com](http://www.bluekcforyou.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](http://www.cciio.cms.gov) or call 1-877-410-6716 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,500 individual / \$3,000 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$7,800 individual / \$15,600 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and penalties for failure to obtain <a href="#">preauthorization</a> 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 <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.BlueKC.com/qhp/pcb">www.BlueKC.com/qhp/pcb</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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	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	\$60 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	Same limitations as primary care.
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">Deductible</a> does not apply	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)	25% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	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> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bluekc.com/2025IFPACASTMO">www.bluekc.com/2025IFPACASTMO</a>	Generic drugs	\$15 <a href="#">copay</a> /fill, <a href="#">Deductible</a> does not apply	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 a 34 day supply.
	Preferred brand drugs	\$30 <a href="#">copay</a> /fill, <a href="#">Deductible</a> does not apply	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 a 34 day supply.
	Non-preferred brand drugs	\$60 <a href="#">copay</a> /fill, <a href="#">Deductible</a> does not apply	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 a 34 day supply.
	<a href="#">Specialty drugs</a>	\$250 <a href="#">copay</a> /fill, <a href="#">Deductible</a> does not apply	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 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)	25% <a href="#">coinsurance</a>	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	25% <a href="#">coinsurance</a>	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> after In- <a href="#">Network Deductible</a>	None
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> after In- <a href="#">Network Deductible</a>	None
	<a href="#">Urgent care</a>	\$45 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	\$45 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	Same limitations as primary care.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	Not covered	<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	25% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	None
	Inpatient services	25% <a href="#">coinsurance</a>	Not covered	<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	25% <a href="#">coinsurance</a>	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.
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	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)	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	Not covered	100 visit Calendar Year maximum.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	Physical: 20 visit Calendar Year maximum. Occupational: 20 visit Calendar Year maximum.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	Physical: 20 visit Calendar Year maximum. Occupational: 20 visit Calendar Year maximum.
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	Not covered	150 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>	25% <a href="#">coinsurance</a>	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>	25% <a href="#">coinsurance</a>	Not covered	<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.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge, <a href="#">Deductible</a> does not apply	Not covered	Limited to 1 Exam(s) per Calendar Year maximum for In- <a href="#">Network</a> . Limited to a child age 18 and younger.
	Children's glasses	25% <a href="#">coinsurance</a>	Not covered	Limited to 1 Pair of Lenses and 1 Frame(s) per Calendar Year maximum or 1 Annual Supply of Contacts per Calendar Year for In- <a href="#">Network</a> 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
- Acupuncture
- Dental care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)

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

- Chiropractic care
- Hearing aids limited to 1 Set(s) hearing aid(s) Every 48 Months
- 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), the Missouri Department of Commerce and Insurance at 800-726-7390 or at [www.insurance.mo.gov](http://www.insurance.mo.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](http://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: Missouri Department of Commerce and Insurance at 800-726-7390 or at [www.insurance.mo.gov](http://www.insurance.mo.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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,730</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,200</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>	\$1,500
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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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.

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- 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).



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