



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 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 ? | \$0. | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| 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 ? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider ? | Yes. See www.BlueKC.com/qhp/bs 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 . |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP 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 | No charge | No charge | Not covered | None |
| | Specialist visit | No charge | No charge | Not covered | Same limitations as primary care. |
| | Preventive care/ screening/immunization | No charge | No charge | 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) | No charge | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | 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/2025IFPACASTKS | Generic drugs | No charge | No charge | 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 | No charge | No charge | 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 | No charge | No charge | 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 |
|--|--|---|--|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Specialty drugs | Not applicable | No charge | 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | 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 | No charge | No charge | Not covered | None |
| If you need immediate medical attention | Emergency room care | No charge | No charge | No charge | None |
| | Emergency medical transportation | No charge | No charge | No charge | None |
| | Urgent care | No charge | No charge | No charge | Same limitations as primary care. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | Not covered | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Physician/surgeon fees | No charge | No charge | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | No charge | Not covered | None |
| | Inpatient services | No charge | No charge | Not covered | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | No charge | No charge | 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 | No charge | No charge | Not covered | None |
| | Childbirth/delivery facility services | No charge | No charge | Not covered | None |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | Not covered | None |
| | Rehabilitation services | No charge | No charge | Not covered | Speech: 90 visit Calendar Year maximum. |
| | Habilitation services | No charge | No charge | Not covered | None |
| | Skilled nursing care | Not covered | Not covered | Not covered | None |
| | Durable medical equipment | No charge | No charge | Not covered | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Hospice services | No charge | No charge | 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 | No charge | Not covered | Limited to a child age 18 and younger. |
| | Children's glasses | No charge | No charge | 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|----------------------|----------------------------|---|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) | |
| | Children's dental check-up | Not covered | 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](#) \$0
- [Specialist](#) [coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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:

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

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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:

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

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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:

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

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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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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 - 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.



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