**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/IFPInfo 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 deductible?** | $9,900 individual / $19,800 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?** | $12,000 individual / $24,000 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/bm/sc 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 | $85 copay/visit, Deductible does not apply | Not covered | No charge for services received from a designated Spira Care Center provider. Other services/procedures that are performed in a physician's office are subject to the network deductible and coinsurance level (excluding lab). |
| | Specialist visit | Visits 1 - 3: $125 copay/visit, Deductible does not apply; Visits 4+: 50% coinsurance | Not covered | Same limitations as primary care. |
| | 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 | Labs performed in an In-Network physician's office will not be subject to the applicable Cost-Sharing if you are required to pay your office visit Copayment. X-rays and other radiology procedures performed in an In-Network physician's office will not be subject to the applicable Cost-Sharing if you are required to pay your office visit Copayment. |
| | 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/2027IFPACAKS | Generic drugs | Low Cost Generic: $5 copay/fill, Deductible does not apply; Generic: $30 copay/fill, Deductible does not apply | 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 34 day supply (retail). |

| 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) | |
| | Preferred brand drugs | $125 copay/fill | 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 34 day supply (retail). |
| | Non-preferred brand drugs | $325 copay/fill | 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 34 day supply (retail). |
| | 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. Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply. |
| **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 | Visits 1 - 3: $125 copay/visit, Deductible does not apply; Visits 4+: 50% coinsurance | Visits 1 - 3: $125 copay/visit, Deductible does not apply; Visits 4+: 50% coinsurance after In-Network Deductible | Same limitations as primary care. |

| 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 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 | $75 copay/visit, Deductible does not apply | 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 |
| | Rehabilitation services | $125 copay/visit, Deductible does not apply | Not covered | Physical and occupational: 90 combined visit Calendar Year maximum. Speech: 90 visit Calendar Year maximum. |
| | Habilitation services | $125 copay/visit, Deductible does not apply | Not covered | Physical and occupational: 90 combined visit Calendar Year maximum. |
| | 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. |

| 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) | |
| | 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 maximum or 1 Annual Supply of Contacts 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)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except for certain conditions)
- Weight loss programs

**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 Department of Insurance 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 Department of Insurance 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 | $9,900 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $9,900 |
| Copayments | $10 |
| Coinsurance | $1,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$11,270** |

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

| | |
|---|---|
| The plan's overall deductible | $9,900 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,200 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,400** |

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

| | |
|---|---|
| The plan's overall deductible | $9,900 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,200 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**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.

Kansas City

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