**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/ksppo 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.cms.gov/glossary or call 1-877-410-6716 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,400 individual / $6,800 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?** | For In-Network providers $5,000 individual / $10,000 family. For Out-of-Network providers $10,000 individual / $20,000 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. | 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/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 | 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge, Deductible does not apply | 40% coinsurance | 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) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | 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/2026Premium | Generic drugs, including Specialty drugs | RxPremier: Retail $20 copay/fill; Mail Order $40 copay/fill | Retail $20 copay/fill then 50% coinsurance; Mail Order $40 copay/fill then 50% coinsurance | 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) and between 35 to 102 day supply (mail order). Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy and are limited to a 34 day supply. |
| | Preferred brand drugs, including Specialty drugs | RxPremier: Retail $60 copay/fill; Mail Order $120 copay/fill | Retail $60 copay/fill then 50% coinsurance; Mail Order $120 copay/fill then 50% coinsurance | 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) and between 35 to 102 day supply (mail order). Prescriptions for a specialty drug will need to be filled at a designated specialty pharmacy and are limited 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) | |
| | Non-preferred brand drugs, including Specialty drugs | RxPremier: Retail $90 copay/fill; Mail Order $180 copay/fill | Retail $90 copay/fill then 50% coinsurance; Mail Order $180 copay/fill then 50% coinsurance | 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) and between 35 to 102 day supply (mail order). 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) | 20% coinsurance | 40% coinsurance | 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 | 20% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance after In-Network Deductible | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance after In-Network Deductible | None |
| | Urgent care | 20% coinsurance | 40% coinsurance | Same limitations as primary care. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance | Your employer participates in an employee assistance program. This program may provide additional mental health or substance abuse benefits. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | 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) | |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Dependent daughters are not covered for maternity services. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | Dependent daughters are not covered for maternity services. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Dependent daughters are not covered for maternity services. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 60 visit Calendar Year maximum. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Physical, occupational, and skeletal manipulation: 60 combined visit Calendar Year maximum. Speech and hearing: 20 combined visit Calendar Year maximum. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | See Rehabilitation Service Limits. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 30 day Calendar Year maximum. Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Prior authorization is required. Failure to obtain approval may result in the cost of the service being your responsibility. |
| | Hospice services | 20% coinsurance | 40% coinsurance | 14 day Lifetime maximum at an inpatient hospice facility. 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 | Not covered | Not covered | None |
| | 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)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Routine eye care
- Routine foot care

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

- Chiropractic care
- Coverage provided outside the United States. See www.bluekc.com/ksppo.
- Infertility treatment
- Private-duty nursing
- 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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) 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, 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 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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 plan's overall deductible | $3,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $3,400 |
| Copayments | $0 |
| Coinsurance | $1,600 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,060** |

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

| | |
|---|---|
| The plan's overall deductible | $3,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $3,400 |
| Copayments | $600 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$4,020** |

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

| | |
|---|---|
| The plan's overall deductible | $3,400 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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

An Independent Licensee of the Blue Cross and Blue Shield Association