Marketplace, BlueCard® and Kansas Provider Networks

BlueCross BlueShield Kansas

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This document provides an overview of the Kansas Provider Networks, the Kansas products sold on and off the Health Insurance Marketplace and information on the BlueCard® network. The information is intended to assist providers and their office staff with changes in the new marketplaces brought about by the Affordable Care Act.

Marketplace background

The Patient Protection and Affordable Care Act (ACA) of 2010 provides for the establishment of health insurance exchanges in each state. In Kansas, there is a federally facilitated exchange marketed as the Health Insurance Marketplace. The purpose of the Marketplace, or exchange, is to allow individual consumers to purchase qualified coverage during an open enrollment period of Nov. 1, 2025 through Jan. 15, 2026. Plans purchased by Dec. 15, 2025 will be effective Jan. 1, 2026.

The Health Insurance Marketplace provides health plan shopping and enrollment services for individuals and families (the individual market). The Marketplace was established to bring structure, transparency, and competition to the health insurance market by offering consumers meaningful plan choices, consistent rules for pricing and coverage, and tools to better understand available options. At its core, the Marketplace aims to enhance competition, improve affordability, and empower individuals with purchasing power.

Health Insurance Marketplace

The Health Insurance Marketplace offers consumers access to a range of health insurance plans and presents product and plan information such as covered services and cost sharing (including deductibles, coinsurance, copayments, and out-of-pocket limits) in a standardized format that makes it easier to compare options across plans.

In addition to providing choice, the Marketplace is designed to deliver transparent information about key plan features, including premium costs and covered benefits, as well as information on issuers' performance in promoting wellness, managing chronic conditions, and improving consumer satisfaction.

Blue Plans that participate in the Marketplace work in collaboration with state and federal governments to support eligibility determination, enrollment, reconciliation, and related operational functions, helping ensure a seamless enrollment experience for consumers in both individual and employer-sponsored coverage.

Kansas operates under a federally facilitated/state partnership Marketplace, available through healthcare.gov. Additional information about Marketplace plans is available at bcbsks.com/individual-and-family-plans.

Health Plan Accreditation

Insurance companies selling products in the Marketplace must have achieved Health Plan Accreditation through an approved accrediting entity. BCBSKS chose URAC as our accrediting organization because our case management and disease management programs have been accredited since 2011. The utilization management program also is URAC accredited and is now a component of Health Plan Accreditation.

In 2014, BCBSKS earned URAC's Full Health Plan Accreditation for commercial (off Marketplace) products, as well as products sold on the Marketplace.

In addition, BCBSKS received Qualified Health Plan (QHP) status from the U.S. Department of Health and Human Services, which is the gold seal approval to sell health insurance products on the Marketplace.

urac®
ACCREDITED
Health Plan
Expires 07/01/2028

urac®
ACCREDITED
Marketplace Health Plan
Expires 07/01/2028

BlueCard for ACA Small Group metallic products (non-EPO)

The Blue Cross and Blue Shield Association (Association) has worked closely with Blue Plans during the years to develop the BlueCard networks that are available to members with out-of-area benefits we refer to as BlueCard PPO.

The enhanced BlueCard program is being referred to as the BlueCard PPO Basic Program. However, the term will not be used for marketing purposes but instead for provider education materials and within the Blue System. There will be new identification (ID) card network logos identifying the member's access to the National Qualified PPO network applicable to the member coverage.

Health identification card and logos

Blue Plan member ID cards

The Association has created a Quick Guide to BCBS Member ID Cards for use by provider offices. When Blue Plan members arrive at your office or facility, remember to ask to see their current member identification cards at each visit. This will help you to identify the product the member has, to obtain health issuer contact information and to assist with claims processing. For more information regarding the member ID cards, please read the Quick Guide to BCBS Member ID Cards, a document compiled by the Association.

BlueCard network logos

Logo	Description	Networks	Product Description
PPO	The PPO logo on the front of the member's ID card means the member has PPO type benefits available for medical services received within or outside of the United States. It also means the provider will be reimbursed for covered services in accordance with the provider's PPO contract with the local Blue Plan. These products are purchased off the Marketplace.	Blue Choice Solutions Choice Networks	Group
PAR	The PAR logo on the front of a member's ID card signifies the member has out-of-area coverage that is not a PPO product. These products can be purchased on or off the Marketplace.	Preferred Care Blue	Individual Small Group
MA|PPO MEDICARE ADVANTAGE	The MA|PPO logo on the front of the member's ID card means the member has in-network coverage through the Kansas Preferred Blue Medicare Advantage Network.	Kansas Preferred Care Blue Medicare Advantage Network	Medicare Advantage
EPO	The EPO logo on the front of the member's ID card means the member has in-network coverage and only emergency out-of-network coverage. These products can be purchased on or off the Marketplace.	Blue Choice Solutions Cap Networks	Individual Group

Kansas provider networks and contracts

BCBSKS provider network contracts are established by a base contract referred to as the Competitive Allowance Program (CAP). Contracts are offered to providers as defined below.

Competitive Allowance Program (CAP)

Competitive Allowance Program (CAP) contracts are offered to eligible professional, ancillary and facility providers located in the BCBSKS service area, which includes all Kansas counties except Johnson and Wyandotte. Providers will be offered network participation following required credentialing and credential committee approval.

Blue Choice

Blue Choice is a hospital PPO network. Hospitals and Ambulatory Surgery Centers that have signed a Blue Choice agreement have agreed to lower reimbursement than the CAP agreement. Ancillary and professional providers who have signed a CAP agreement are automatically enrolled in the Blue Choice PPO Network and receive the same CAP reimbursement.

Exclusive Provider Network

Exclusive Provider Network is the network that represents all providers enrolled in Blue Choice. EPO products have only in-network and emergency benefits.

Kansas Blue Medicare Select Supplement

Kansas Blue Medicare Select Supplement is a supplemental Medicare contract that requires the hospital to write-off the inpatient deductible. Participation is voluntary with the desire for one hospital per designated county participating in Kansas Blue Medicare Select Supplement.

Kansas Preferred Blue Medicare Advantage

Launched in 2020, Kansas Preferred Blue Medicare Advantage is the network for Blue MA, an authorized Medicare Advantage Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage and prescription drug insurance plans in the senior market.

Value Blue

Value Blue is a network of providers who have agreed to accept 50 % of the Blue Choice network reimbursement.

Provider directories

Members will automatically be directed to Blue providers in BlueCard PPO Basic, BlueCard PPO or BlueCard Traditional networks by typing in their prefix into the provider directory on the BCBSKS website, mobile version or mobile app, or by providing the prefix when calling the BlueCard Access call center.

2026 BCBSKS product offerings

BCBSKS is offering benefit plans for Kansas consumers to have the option of purchasing coverage through the Marketplace or directly from BCBSKS. The various plans offer different levels of benefits and pricing to meet individual needs.

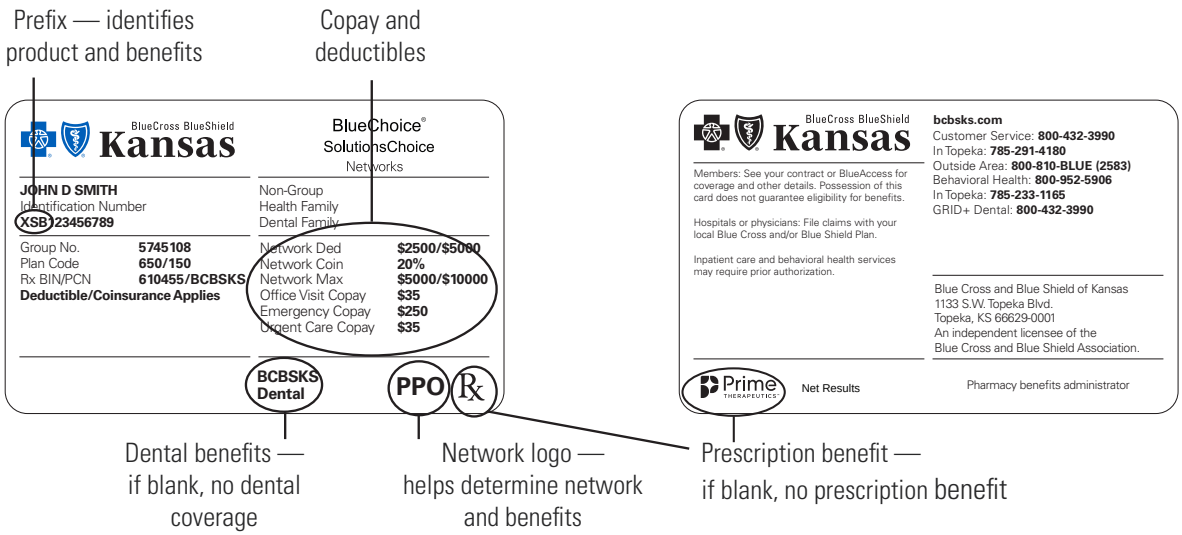
BCBSKS member ID card prefixes

The ID card prefixes for BCBSKS members purchasing products on or off the Marketplace are listed below.

Prefix	Network and product description
XST	Blue Choice Individual off Marketplace
XSN	EPO—Individual on Exchange
XSZ	EPO—Individual off Exchange
M3A	Kansas Preferred Blue Medicare Advantage

Preferred Care Blue on KS member ID cards

- Preferred Care Blue (Kansas City's network) will be on the ID cards for base plans with Blue Choice and BlueCAP (Marketplace network).
- Preferred Care Blue will not be on the ID cards for the limited network plans. These cards will have Blue Choice and BlueCAP.



EPO differences from PPO

EPO products are different than PPO products in Kansas. PPO products cannot vary more than 30% of the actuarial value between in- and out-of-network benefits. EPO products are not limited to the 30% differential between in- and out-of-network benefits. Out-of-network services can be classified as not covered except in some instances (i.e. emergency services, services not provided in the network, etc.).

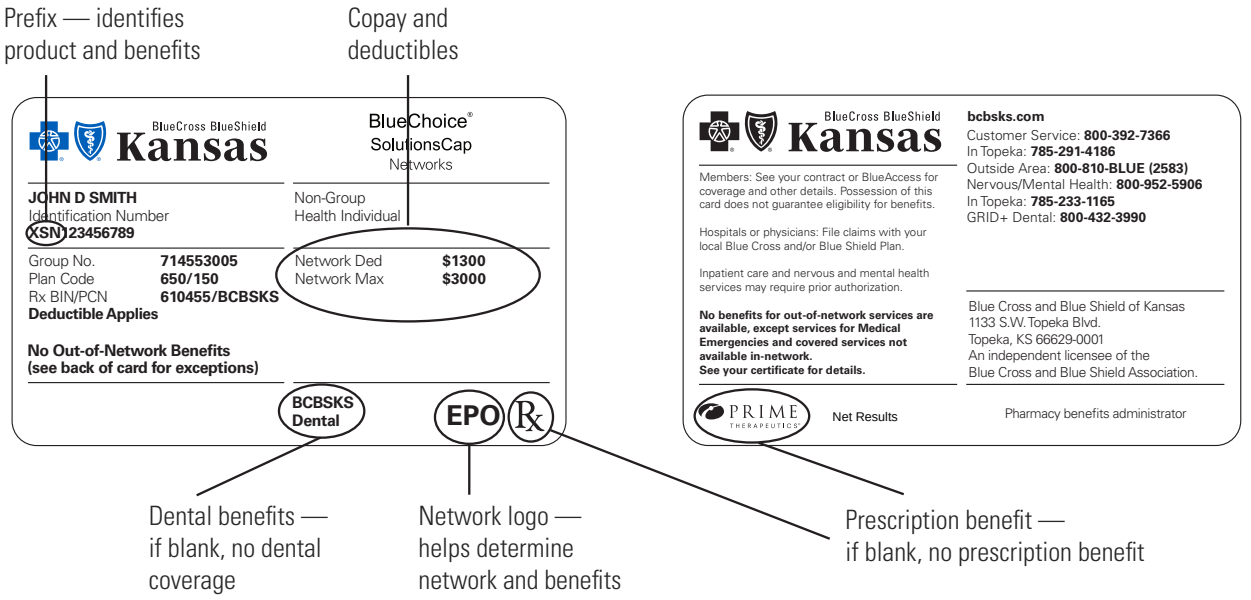
Provider network

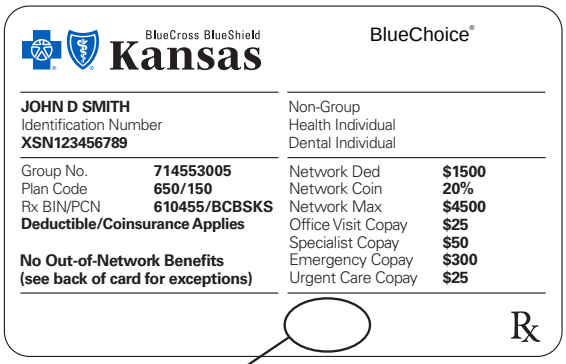
Professional providers who are CAP contracted also are Blue Choice and EPO contracted. When admitting an EPO patient to a hospital, providers are asked to confirm the admitting hospital is in the Blue Choice Hospital network to protect the member from any out-of-network charges. Contracting providers with BCBSKS/Blue Choice will receive the same reimbursement for services provided to EPO members as they do for all BCBSKS members. No additional contracting is necessary.

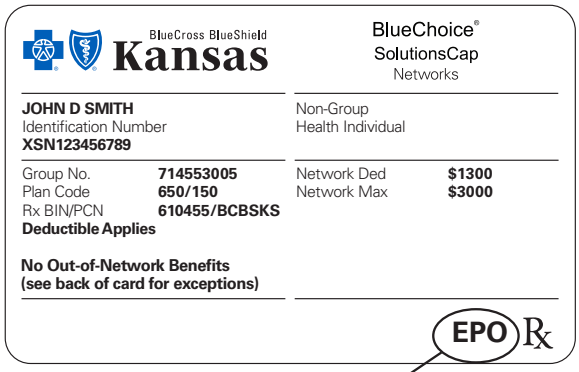
2026 EPO member ID card examples

The EPO Member ID card has a logo which signifies the member has out-of-area coverage for emergency services or services not provided in network.

The EPO ID card for members health and dental benefits will have the dental logo at the bottom of the card.







Claims filing and other procedures

Marketplace individual grace period

Under the Affordable Care Act (ACA), individuals enrolled in Marketplace coverage who receive an advance premium tax credit (APTC) are entitled to a three-month (90-day) grace period if they become delinquent in paying their share of the premium, provided the member has paid at least one full month's premium during the benefit year.

During the first month of the grace period, coverage remains active and claims are paid as usual. If premium payment is not received, Blue Cross and Blue Shield of Kansas will pend claims during the second and third months of the grace period. Providers will be notified by letter when a member's claims are pended due to non-payment of premium.

If the delinquent premium is paid in full within the grace period, all pended claims will be released and processed. If premium payment is not received by the end of the three-month grace period, coverage will be terminated retroactive to the end of the first month of the grace period, and all pended claims from the second and third months will be denied for no coverage. Providers will be notified of the denial through their remittance advice.

During the three-month grace period, providers may not bill the member for covered services. After coverage termination and notification from BCBSKS via remittance advice, providers may bill the member for services rendered during the second and third months of the grace period that were not paid.

Referring provider required on claims for Indian Health (Native American) Services

As of January 1, 2014 under the ACA, insurers covering Native Americans who meet defined financial criteria are prohibited from applying cost sharing for items or services furnished directly by an Indian Health Service (IHS), an Indian tribe, tribal organization or urban Indian organization, or through a referral.

To administer benefits correctly for the Native American population, the treating provider must include the referring provider name and NPI when submitting a claim for services provided to an insured Native American, when these members present their paperwork to the provider.

Institutional providers: The referring provider's name and NPI is submitted in the Field Locator (FL) 78 of the UB-04 claim form. The electronic equivalent to FL 78 is 2310F (claim level) or 2420D (line level).

Professional providers: The referring provider's name and NPI is submitted in the 2310A (claim level) and/or 2420F (line level) electronically, or on paper in box 17 and 17b when submitting the claim.

Commercial risk adjustment

The Affordable Care Act (ACA) established a guaranteed-issue environment for the individual and small-group markets beginning Jan. 1, 2014. This means eligible individuals can enroll in health coverage without completing health history questionnaires and cannot be denied coverage due to past or current medical conditions. Coverage is available during open enrollment periods or following a qualifying life event.

To support a fair and competitive marketplace, the ACA also introduced Commercial Risk Adjustment (CRA). This program is designed to ensure health plans compete based on value, quality, and efficiency rather than the health status of the members they serve. Risk adjustment uses member-level risk scores (estimates of expected health care costs) to calculate each issuer's overall risk profile.

The program redistributes funds among health plans based on these risk profiles. Plans with healthier-than-average enrolled populations contribute to the program, while plans enrolling members with higher health care needs receive payments. This process helps offset the cost of caring for higher-risk members and promotes stability and affordability across the marketplace.

Risk adjustment helps ensure that health plans are funded fairly based on the health needs of the members they serve. To do this accurately, it's important that risk adjustment scores, for both members and health plans, are calculated in a consistent and equitable way.

These scores are based on information such as a member's age and gender, the type of plan selected, and medical diagnoses documented by providers during visits and reflected on claims or in medical records. Each year, current claims data is used to reflect members' health needs as accurately as possible.

Because diagnosis information plays a key role in this process, complete and accurate medical documentation is essential. When a claim doesn't fully capture a member's health conditions, it can create gaps in the risk adjustment process. Clear and specific diagnosis coding helps ensure that health plans receive appropriate funding to support the care and services members rely on.

Risk adjustment data validation audit

Risk adjustment calculations are based on health care claims from the current year and help ensure health plans receive appropriate funding to support members' care. To keep this process accurate, it's important that the medical conditions listed on claims match what is documented in a member's medical record.

Each year, the U.S. Department of Health and Human Services (HHS) requires health plans to complete a routine risk adjustment audit for a small sample of members, typically 200 individuals. These audits are a standard part of overseeing the health insurance marketplace.

During an audit, diagnosis information submitted on claims is compared to medical records to confirm accuracy. Medical records serve as the official source when questions arise, helping ensure that health conditions are reflected correctly. This process does not affect a member's benefits or coverage.

When the review identifies opportunities for improvement, the health plan works with providers to offer education and guidance. This helps ensure future claims accurately reflect the care documented during visits, supporting a fair and reliable system for everyone.

Each year, CMS selects the members included in this review. The health plan coordinates the secure collection of medical records, and an independent auditing organization completes the required review in accordance with federal guidelines.

Medical records requests

Effective medical record retrieval services play a fundamental role in driving optimal-quality reporting outcomes and ensuring appropriate risk scores.

Specifically, the ACA's Commercial Risk Adjustment process and for the U.S. Department of Health and Human Services Risk Adjustment Data Validation Audit, BCBSKS conducts medical record requests. Requests for member records will be received directly from BCBSKS' Risk Adjustment Outreach Staff.

As outlined within the provider contract, all pertinent and complete medical records must be provided or made available by the contracting provider. Following are the methods records may be submitted:

- Email to: risk.adjustment@bcbsks.com
- Secure fax to **785-290-0762**
- By mail to:
  Blue Cross and Blue Shield of Kansas, cc853B3
  PO Box 239
  Topeka, KS 66601
- Or by mail service (FedEx, UPS, etc.) to:
  Blue Cross and Blue Shield of Kansas, cc8531B3
  1133 SW Topeka Blvd.
  Topeka, KS 66629
- For minimal disruption, BCBSKS can coordinate remote access through the provider's EMR system. To elect this option, please contact Katie McAleese, CPC, CRC at katie.mcaleese@bcbsks.com or **785-291-7415**.

HIPAA/privacy

BCBSKS and third-party vendors requesting medical records are contractually bound to preserve the confidentiality of members' protected health information (PHI) obtained from medical records, in accordance with HIPAA regulations.

Please note that patient-authorized information releases are not required for you to comply with these requests for medical records.

Providers are permitted to disclose PHI to issuers without authorization from the patient when both the provider and issuer had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c)(4)]. For more information regarding privacy rule language, please visit hhs.gov/ocr/privacy.

Visit us at bcbsks.com

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