2025 Plan Year

Health plans for businesses with up to 50 employees

BlueCross BlueShield Kansas

bcbsks.com/smallbiz

Health insurance the Kansas Way

80 years of commitment, compassion and community.

From day one, our company culture has been based on Kansans serving Kansans. We exist to provide peace of mind and access to a better quality of life for our members and all Kansans. Three words help to sum up the values our leadership and employees have long held close: commitment, compassion and community.

"As the state's largest health insurer, Blue Cross and Blue Shield of Kansas is uniquely positioned to improve the health of Kansans. We understand our responsibility to provide members peace of mind as they experience happy moments of life, as well as life's challenges. We'll be there with the largest provider network, answers to your questions, and will process your claims accurately."

Matt All
President/CEO

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Understanding health insurance for your business

Find answers to common questions on our Employer Resource Center at bcbsks.com/answers.

Should I give my employees a raise or offer health insurance?

With a salary increase, you and your employee will take a tax hit. Offering health insurance also shows your employees that their overall health is important to you.

Do I have to offer coverage to all my employees?

Groups with fewer than 50 full-time employees are not required to offer insurance to all employees. You have the option to limit coverage to certain categories of employees.

How much of the premium do I have to pay?

You choose. Unlike many health insurance companies, Blue Cross does not set a requirement for minimum premium contribution.

Types of enrollment

Small businesses can choose from four types of enrollment for their employees.

Single membership

Covers the employee only

Employee and spouse

Covers the employee and his or her spouse

Employee and child(ren)

Covers the employee and his or her eligible dependent children, but does not provide coverage to a spouse

Family membership

Covers the employee, spouse and eligible dependent children

Networks and service areas

Across the state, we've got you covered. Our dominant network size provides members access to discounted fees with all participating doctors and hospitals – and that means savings for you.

The largest provider network in Kansas

99% of doctors covered
100% of eligible hospitals covered

Blue Cross and Blue Shield of Kansas serves all counties in Kansas except Johnson and Wyandotte.

A complete healthcare package
Offering a complete healthcare package gives you a powerful recruitment and retention tool while also keeping your valuable workforce healthy and productive. Blue Cross offers dental insurance, vision, hospital indemnity, cancer and international travel health insurance.

Coverage that's good for you

The right health plan plays an important role in your success as a business owner. With an insurance plan from Blue Cross, you benefit from:

- Choice and convenience
- Support from right here in Kansas
- Valued member status

The benefits of Blue:

Choice and convenience

- Health, vision, dental, cancer, hospital indemnity, disability and life plans
- Simplified plan administration
- Cost control to work within budget

Local support

- Local customer service and support for account questions
- A dedicated account representative
- Easy annual renewal process

Valued member status

- Kansans taking care of Kansans
- Quick resolution because we know you're busy
- Specialists who work with small businesses and know you

Prescription drug coverage

You pay less when prescriptions are filled at an in-network pharmacy and more at an out-of-network pharmacy.

In-network

- Walgreens
- Walmart/Sam's Club
- Hy-Vee

Out-of-network

- CVS (including Target)
- Costco

This list is only a sample, not a complete list of pharmacies.

Prescription drug tiers (formulary)

Prescription drugs fall into five different tiers. The prescription drug tiers are also known as your formulary. For more information, visit https://www.bcbsks.com/prescription-drugs

1 TIER | 2 TIER | 3 TIER | 4 TIER | 5 TIER

$ LOWEST COST ⟷ HIGHEST COST $$

Where to get care

Knowing where to get care when you are not feeling well should be easy. See our chart below to help you make that decision.

	Doctor's office	Telehealth	Urgent care	Emergency room
When to go	When you have any medical concern, your primary doctor knows you best and has your medical records. Your doctor oversees your care and can provide routine services and preventive exams. Your doctor can help you manage your medication and refer you to a specialist, if needed.	When you have a non-emergent health condition and don't want to leave your home or office, a virtual doctor's visit is an option. Telehealth lets you interact with a board-certified doctor at your convenience on your phone, tablet or computer.	When you need care quickly, but it is not an emergency and your primary doctor may not be available. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.	When you need immediate treatment of a very serious or critical condition. The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention.
Type of care[1]	• Routine checkups • Immunizations • Preventive services • Manage your overall health	• Cold/flu • Fever • Rash • Sinus infection • Pink eye • Ear infection	• Common infections (e.g., strep throat) • Minor skin conditions (e.g., poison ivy) • Flu and fever (below 104°) • Earache/sore throat	• Heavy bleeding • Large open wounds • Chest pain • Major burns • Severe head injury • Broken bones • Shortness of breath
Cost and wait times[2]	**Low cost** • Often requires a copay and/or coinsurance • Normally requires an appointment • Little wait time with a scheduled appointment	**Low cost** • $0 copays for virtual visits with your in-network doctor or with Amwell. Visit bcbsks.com/telehealth to learn more. • Usually available 24/7 with very little wait time	**Medium cost** • Often requires a copay and/or coinsurance usually higher than an office visit • Walk-in patients are welcome, but waiting periods may be longer as patients with more urgent needs will be treated first	**High cost** • Often requires a much higher copay and/or coinsurance • Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

[1] This is a sample list of services and may not be all-inclusive.

[2] Cost and time information represent averages only and are not tied to a specific condition, level of coverage or treatment. Your out-of-pocket costs will vary depending on your plan type.

Member tools and benefits

All BlueCare plans include powerful tools and benefits for your employees to manage their health and wellbeing.

BlueAccess®

Our secure online member portal and mobile app allows you to:

- View benefits, including eligibility and deductible/coinsurance information.
- Check your claims.
- View, download and monitor medical expenses through your Explanation of Benefits (EOBs).
- View, download or print your digital ID card.
- Find out if your prescription is covered and what your cost will be.

MyPrime.com

A secure website providing you a wide range of pharmacy benefit information. Offered through Prime Therapeutics, our pharmacy benefit manager, the website (accessible through BlueAccess) includes:

- Food and drug interactions.
- Generic drugs availability.
- Side-by-side cost comparisons of brand-name and generic drugs.
- The ability to review complete prescription history.

HealthyOptions®

A powerful set of services, tools and one-on-one support to live a healthy life at no extra cost to you. Programs available include:

- Disease management for members with chronic health conditions.
- Case management for members with complex medical conditions.
- Wellness management tools to help members become tobacco-free, manage stress, have a healthy pregnancy or lose weight.
- Strive, powered by WebMD ONE, provides members with a recommended health action plan and other tools to help you achieve your unique well-being goals. Access Strive on the go with the "Wellness At Your Side" app on your phone.
- Educational resources through our Wellness media library.

Visit **bcbsks.com/BeHealthy** to learn more.

Telehealth

You can have a virtual doctor's visit from your smartphone or computer – right when you need it. See a doctor from the comfort of your own home – or anywhere else for that matter. Safe and secure, it's the quality care you need, made easier. AmWell virtual visits are covered at 100%. Virtual visits with an in-network non-AmWell provider are covered at 100%.

Blue365®

Get exclusive deals and discounts for things like:

- Gym memberships.
- Healthy eating and meal delivery.
- Fitness products.
- Personal care: Hearing and vision.

Complete your coverage

Many businesses choose to offer their employees a complete package of healthcare options.

Dental insurance coverage

- Vast dental plan options
- Comprehensive coverage with preventive, primary and major care
- Additional services at 100% or discounted rates
- Robust network including over 90% of Kansas dentists

Vision insurance

Vision insurance through EyeMed® offers an outstanding member experience, focused on choice, convenience and savings.

Secure Hospital Indemnity Plan℠

- Pays cash to you when you're hospitalized
- Supplements to help with expenses not covered by health insurance
- Pays double benefits when in ICU
- Guaranteed issue coverage with a group plan

Secure 300 Cancer Plan℠

- Pays cash for screenings and treatment
- Supplements to help with transportation, meals and other expenses
- Annual wellness screening benefit
- Inpatient and outpatient benefit
- Guaranteed issue coverage with a group plan

GeoBlue® for travel abroad

Whether you're traveling abroad for business or pleasure, Blue Cross offers affordable medical and trip protection plans through GeoBlue®. Enrollment is easy and takes only minutes to ensure a worry-free travel experience wherever you go, whenever you need it for you and your loved ones. Learn more and get a quote at **bcbsks.com/travel**

Compare plans

Each plan falls into a bronze, silver, gold or platinum category, depending on coverage costs.

Bronze

- Lowest monthly premium
- Highest costs when you need care

Silver

- Moderate monthly premium
- Moderate costs when you need care

Gold

- High monthly premium
- Low costs when you need care

Platinum

- Highest monthly premium
- Lowest costs when you get care

All of our BlueCare plans offer:

- Wellness benefits
- Adult eye exams
- Emergency services
- 99% of doctors covered
- 100% of hospitals covered
- Pediatric dental and vision
- Mental illness/substance use disorder services

For plan exclusions, please refer to the glossary.

BlueCare BronzeSG 5000/25

2025 Plan Year – Expanded Bronze level

General	In-Network	Out-of-Network
Deductible	$5,000 per person / $10,000 family	$7,000 per person / $14,000 family
Coinsurance (percentage paid by member)	50%	70%
Coinsurance maximum	Same as the annual out-of-pocket max	$7,300 per person / $14,600 family
Annual out-of-pocket maximum	$8,750 per person/$17,500 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 copay for the first visit, then subject to deductible and 50% coinsurance	Deductible then 70% coinsurance
Home and office visits – Specialists	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 70% coinsurance
Prescription drug coverage		
Prescription drugs	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Mail order drugs	Deductible then 50% coinsurance **Specialty drugs are not covered**	Deductible then 70% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Inpatient surgery physician/surgical	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Outpatient surgery physician/surgical	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Emergency Room	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Injections	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 70% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 50% coinsurance	Deductible then 70% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Outpatient habilitation	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Hospice	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Home social work visits	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 50% coinsurance	Deductible then 70% coinsurance
Mental illness/substance use disorders – outpatient services	$0. Mental health, behavioral health and substance use services are without cost share.	Deductible then 70% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

BlueCare BronzeSG HDHP 7100/0

2025 Plan Year – Expanded Bronze level

General	In-Network	Out-of-Network
Deductible	$7,100 per person / $14,200 family	$13,000 per person / $26,000 family
Coinsurance (percentage paid by member)	0%	0%
Coinsurance maximum	Same as the annual out-of-pocket max	N/A
Annual out-of-pocket maximum	$7,100 per person / $14,200 family	N/A
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	Deductible then $0
Home and office visits – Specialists	Deductible then $0	Deductible then $0
Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	Deductible then $0
Prescription drug coverage		
Prescription drugs*	Deductible then $0	Deductible then $0
Mail order drugs*	Deductible then $0 **Specialty drugs are not covered**	Deductible then $0 **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then $0	Deductible then $0
Inpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Inpatient facility fee *Requires pre-admission certification*	Deductible then $0	Deductible then $0
Outpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then $0	Deductible then $0
Emergency Room	Deductible then $0	Deductible then $0
Injections	Deductible then $0	Deductible then $0
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0
Pediatric vision (for ages 0-19)	Deductible then $0	Deductible then $0
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then $0	Deductible then $0
Outpatient habilitation	Deductible then $0	Deductible then $0
Hospice	Deductible then $0	Deductible then $0
Home social work visits	Deductible then $0	Deductible then $0
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then $0	Deductible then $0
Mental illness/substance use disorders – outpatient services	Deductible then $0	Deductible then $0
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	Yes	Yes
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare SilverSG 3000/35

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$3,000 per person / $6,000 family	$3,500 per person / $7,000 family
Coinsurance (percentage paid by member)	50%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$14,000 per person / $28,000 family
Annual out-of-pocket maximum	$9,200 per person / $18,400 family	N/A
Doctor's office visits		
Home and office visits – Primary	$35 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$70 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Inpatient surgery physician/surgical	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Injections	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 50% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$35 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare SilverSG HDHP 5100/0

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$5,100 per person / $10,200 family	$10,000 per person / $20,000 family
Coinsurance (percentage paid by member)	0%	0%
Coinsurance maximum	N/A	N/A
Annual out-of-pocket maximum	$5,100 per person / $10,200 family	N/A
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	Deductible then $0
Home and office visits – Specialists	Deductible then $0	Deductible then $0
Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	Deductible then $0
Prescription drug coverage		
Prescription drugs*	Deductible then $0	Deductible then $0
Mail order drugs*	Deductible then $0 **Specialty drugs are not covered**	Deductible then $0 **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then $0	Deductible then $0
Inpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Inpatient facility fee *Requires pre-admission certification*	Deductible then $0	Deductible then $0
Outpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then $0	Deductible then $0
Emergency Room	Deductible then $0	Deductible then $0
Injections	Deductible then $0	Deductible then $0
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0
Pediatric vision (for ages 0-19)	Deductible then $0	Deductible then $0
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then $0	Deductible then $0
Outpatient habilitation	Deductible then $0	Deductible then $0
Hospice	Deductible then $0	Deductible then $0
Home social work visits	Deductible then $0	Deductible then $0
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then $0	Deductible then $0
Mental illness/substance use disorders – outpatient services	Deductible then $0	Deductible then $0
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	Yes	Yes
Change for 2025		

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BlueCare SilverSG HDHP 6000/0

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$6,000 per person / $12,000 family	$10,000 per person / $20,000 family
Coinsurance (percentage paid by member)	0%	0%
Coinsurance maximum	N/A	N/A
Annual out-of-pocket maximum	$6,000 per person / $12,000 family	N/A
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	Deductible then $0
Home and office visits – Specialists	Deductible then $0	Deductible then $0
Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	Deductible then $0
Prescription drug coverage		
Prescription drugs*	Deductible then $0	Deductible then $0
Mail order drugs*	Deductible then $0 **Specialty drugs are not covered**	Deductible then $0 **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then $0	Deductible then $0
Inpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Inpatient facility fee *Requires pre-admission certification*	Deductible then $0	Deductible then $0
Outpatient surgery physician/surgical	Deductible then $0	Deductible then $0
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then $0	Deductible then $0
Emergency Room	Deductible then $0	Deductible then $0
Injections	Deductible then $0	Deductible then $0
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0
Pediatric vision (for ages 0-19)	Deductible then $0	Deductible then $0
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then $0	Deductible then $0
Outpatient habilitation	Deductible then $0	Deductible then $0
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Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	Yes	Yes
Change for 2025		

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BlueCare SilverSG 3100/35

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$3,100 per person / $6,200 family	$5,000 per person / $10,000 family
Coinsurance (percentage paid by member)	40%	60%
Coinsurance maximum	Same as the annual out-of-pocket max	$5,000 per person / $10,000 family
Annual out-of-pocket maximum	$9,200 per person / $18,400 family	N/A
Doctor's office visits		
Home and office visits – Primary	$35 copay for 3 visits, then subject to deductible and 40% coinsurance	Deductible then 60% coinsurance
Home and office visits – Specialists	$70 copay per visit	Deductible then 60% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 60% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 60% coinsurance
Mail order drugs*.	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 60% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Inpatient surgery physician/surgical	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Outpatient surgery physician/surgical	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Emergency Room	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Injections	Deductible then 40% coinsurance	Deductible then 60% coinsurance
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Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services: Deductible then 40% coinsurance	Deductible then 60% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Outpatient habilitation	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Hospice	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Home social work visits	Deductible then 40% coinsurance	Deductible then 60% coinsurance
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Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 40% coinsurance	Deductible then 60% coinsurance
Mental illness/substance use disorders – outpatient services	$35 copay for 3 visits, then subject to deductible and 40% coinsurance	Deductible then 60% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare SilverSG 6300/35

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$6,300 per person / $12,600 family	$8,000 per person / $16,000 family
Coinsurance (percentage paid by member)	40%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$5,000 per person / $10,000 family
Annual out-of-pocket maximum	$9,200 per person / $18,400 family	N/A
Doctor's office visits		
Home and office visits – Primary	$35 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$70 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Inpatient surgery physician/surgical	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible then 40% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Injections	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 40% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 40% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 40% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$35 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare GoldSG 1500/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$1,500 per person / $3,000 family	$3,500 per person / $7,000 family
Coinsurance (percentage paid by member)	20%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$7,000 per person / $14,000 family
Annual out-of-pocket maximum	$4,950 per person / $9,900 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 copay for 5 visits, then subject to deductible and 20% coinsurance	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 copay	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2 / $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Inpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Emergency Room	$300 copay then subject to deductible and 20% coinsurance	$300 copay then subject to deductible and 20% coinsurance
Injections	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services: Deductible then 20% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare GoldSG 1000/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$1,000 per person / $2,000 family	$4,000 per person / $8,000 family
Coinsurance (percentage paid by member)	30%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$4,000 per person / $8,000 family
Annual out-of-pocket maximum	$6,600 per person / $13,200 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Inpatient surgery physician/surgical	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 30% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Injections	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 30% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 30% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare GoldSG 2000/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$2,000 per person / $4,000 family	$5,000 per person / $10,000 family
Coinsurance (percentage paid by member)	30%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$3,000 per person / $6,000 family
Annual out-of-pocket maximum	$6,000 per person / $12,000 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Inpatient surgery physician/surgical	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 30% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Injections	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 30% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 30% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 30% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare PlatinumSG 500/25

2025 Plan Year – Platinum level

General	In-Network	Out-of-Network
Deductible	$500 per person / $1,000 family	$3,000 per person / $6,000 family
Coinsurance (percentage paid by member)	20%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$3,000 per person / $6,000 family
Annual out-of-pocket maximum	$1,500 per person / $3,000 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Inpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 20% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Injections	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 20% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare PlatinumSG 0/0

2025 Plan Year – Platinum level

General	In-Network	Out-of-Network
Deductible	$0	$1,500 per person / $3,000 family
Coinsurance (percentage paid by member)	50%	50%
Coinsurance maximum	Same as the annual out-of-pocket max	$5,500 per person / $11,000 family
Annual out-of-pocket maximum	$1,250 per person / $2,500 family	N/A
Doctor's office visits		
Home and office visits – Primary	Subject to 50% coinsurance	Deductible then 50% coinsurance
Home and office visits – Specialists	Subject to 50% coinsurance	Deductible then 50% coinsurance
Telemedicine is subject to the same cost sharing provisions as non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	Subject to 50% coinsurance	Deductible then 50% coinsurance
Mail order drugs*	Subject to 50% coinsurance **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Subject to 50% coinsurance	Subject to 50% coinsurance
Inpatient surgery physician/surgical	Subject to 50% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Subject to 50% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Subject to 50% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Subject to 50% coinsurance	Deductible then 50% coinsurance
Emergency Room	Subject to 50% coinsurance	Subject to 50% coinsurance
Injections	Subject to 50% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Subject to 50% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Subject to 50% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Subject to 50% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Subject to 50% coinsurance	Deductible then 50% coinsurance
Hospice	Subject to 50% coinsurance	Deductible then 50% coinsurance
Home social work visits	Subject to 50% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Subject to 50% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	Subject to 50% coinsurance	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare PlatinumSG 0/25

2025 Plan Year – Platinum level

General	In-Network	Out-of-Network
Deductible	$0	$1,500 per person / $3,000 family
Coinsurance (percentage paid by member)	20%	50%
Coinsurance maximum	N/A	$4,500 per person / $9,000 family
Annual out-of-pocket maximum	$3,000 per person / $6,000 family	N/A
Doctor's office visits		
Home and office visits – Primary & Telemedicine	$25 copay per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 copay per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Subject to 20% coinsurance	Subject to 20% coinsurance
Inpatient surgery physician/surgical	Subject to 20% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Subject to 20% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Subject to 20% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Subject to 20% coinsurance	Deductible then 50% coinsurance
Emergency Room	Subject to 20% coinsurance	Subject to 20% coinsurance
Injections	Subject to 20% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 20% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Subject to 20% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Subject to 20% coinsurance	Deductible then 50% coinsurance
Hospice	Subject to 20% coinsurance	Deductible then 50% coinsurance
Home social work visits	Subject to 20% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Subject to 20% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 copay per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare PlatinumSG 1000/25

2025 Plan Year – Platinum level

General	In-Network	Out-of-Network
Deductible	$1,000 per person / $2,000 family	$3,000 per person / $6,000 family
Coinsurance (percentage paid by member)	20%	50%
Coinsurance maximum	N/A	$3,000 per person / $6,000 family
Annual out-of-pocket maximum	$1,700 per person / $3,400 family	N/A
Doctor's office visits		
Home and office visits – Primary	$25 per visit	Deductible then 50% coinsurance
Home and office visits – Specialists	$50 per visit	Deductible then 50% coinsurance
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	Deductible then 50% coinsurance
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Deductible then 50% coinsurance
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	Deductible then 50% coinsurance **Specialty drugs are not covered**
Medical services		
Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Inpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Inpatient facility fee *Requires pre-admission certification*	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient surgery physician/surgical	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Emergency Room	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Injections	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits, all other services: Deductible then 20% coinsurance	Deductible then 50% coinsurance
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient habilitation	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Hospice	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Home social work visits	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Mental illness/substance use disorders – outpatient services	$25 per visit	Deductible then 50% coinsurance
Other		
Lifetime maximum	Unlimited for each covered person	Unlimited for each covered person
Eligible dependents	Covered to age 26	Covered to age 26
HSA compliant	No	No
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

	A	B	C	D
BlueCare Quad Option 1	**BlueCare PlatinumSG 500/25** Platinum level	**BlueCare GoldSG 1000/25** *Gold level*	**BlueCare GoldSG 2000/25** *Gold level*	**BlueCare SilverSG HDHP 5100/0[§]** *Silver level*
Deductible	$500 / $1,000	$1,000 / $2,000	$2,000 / $4,000	$5,100 / $10,200
Coinsurance (% paid by member)	20%	30%	30%	0%
Annual out-of-pocket maximum	$1,500 / $3,000	$6,600 / $13,200	$6,000 / $12,000	$5,100 / $10,200
Home and office visits – Primary	$25	$25	$25	Subject to deductible
Home and office visits – Specialists	$50	$50	$50	Subject to deductible
	Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.			Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.
Emergency room	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Inpatient hospital services *Requires pre-admission certification*	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Preventive care	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share
Immunizations	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient lab, radiology and advanced imaging	$300 paid at 100% then subject to deductible/coinsurance	$300 paid at 100% then subject to deductible/coinsurance	$300 paid at 100% then subject to deductible/coinsurance	Subject to deductible
Prescription drugs – retail*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Subject to deductible
Mail order drugs**	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	Subject to deductible
Pediatric dental (ages 0-19)	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible
Pediatric vision (ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Subject to deductible
Outpatient rehabilitation	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient habilitative	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient surgery	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Mental illness/substance use disorders – outpatient services	$25	$25	$25	Subject to deductible
Home social work visits	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Change for 2025				

[†] Subject to deductible/coinsurance after copay
* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.
** Specialty drugs are not covered
[§] HSA compliant

	A	B	C	D
BlueCare Quad Option 2	**BlueCare GoldSG 1000/25** *Gold level*	**BlueCare GoldSG 2000/25** *Gold level*	**BlueCare SilverSG 3100/35** *Silver level*	**BlueCare SilverSG HDHP 5100/0[§]** *Silver level*
Deductible	$1,000 / $2,000	$2,000 / $4,000	$3,100 / $6,200	$5,100 / $10,200
Coinsurance (% paid by member)	30%	30%	40%	0%
Annual out-of-pocket maximum	$6,600 / $13,200	$6,000 / $12,000	$9,200 / $18,400	$5,100 / $10,200
Home and office visits – Primary	$25	$25	$35 for 3 visits[†]	Subject to deductible
Home and office visits – Specialists	$50	$50	$70	Subject to deductible
	Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.			Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.
Emergency room	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Inpatient hospital services *Requires pre-admission certification*	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Preventive care	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share
Immunizations	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient lab, radiology and advanced imaging	$300 paid at 100% then subject to deductible/coinsurance	$300 paid at 100% then subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Prescription drugs – retail*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Subject to deductible
Mail order drugs**	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	Subject to deductible
Pediatric dental (ages 0-19)	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible
Pediatric vision (ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Subject to deductible
Outpatient rehabilitation	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient habilitative	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient surgery	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Mental illness/substance use disorders - outpatient services	$25	$25	$35 for 3 visits[†]	Subject to deductible
Home social work visits	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Change for 2025				

[†] Subject to deductible / coinsurance after copay
* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.
** Specialty drugs are not covered
[§] HSA compliant

	A	B	C	D
BlueCare Quad Option 3	**BlueCare SilverSG 3100/35** *Silver level*	**BlueCare SilverSG 6300/35** *Silver level*	**BlueCare SilverSG HDHP 5100/0[§]** *Silver level*	**BlueCare BronzeSG HDHP 7100/0[§]** *Expanded Bronze level*
Deductible	$3,100 / $6,200	$6,300 / $12,600	$5,100 / $10,200	$7,100 / $14,200
Coinsurance (% paid by member)	40%	40%	0%	0%
Annual out-of-pocket maximum	$9,200 / $18,400	$9,200 / $18,400	$5,100 / $10,200	$7,100 / $14,200
Home and office visits – Primary	$35 for 3 visits [†]	$35	Subject to deductible	Subject to deductible
Home and office visits – Specialists	$70	$70	Subject to deductible	Subject to deductible
	Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.	
Emergency room	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Inpatient hospital services *Requires pre-admission certification*	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Preventive care	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share
Immunizations	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Outpatient lab, radiology and advanced imaging	Subject to deductible/coinsurance	$300 paid at 100% then subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Prescription drugs – retail*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Subject to deductible	Subject to deductible
Mail order drugs**	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	Subject to deductible	Subject to deductible
Pediatric dental (ages 0-19)	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible	Cleanings and periodic evaluations covered at 100%, then subject to deductible
Pediatric vision (ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Outpatient rehabilitation	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Outpatient habilitative	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Outpatient surgery	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Mental illness/substance use disorders - outpatient services	$35 for 3 visits [†]	$35	Subject to deductible	Subject to deductible
Home social work visits	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible	Subject to deductible
Change for 2025				

[†] Subject to deductible / coinsurance after copay
* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.
** Specialty drugs are not covered
[§] HSA compliant

	A	B	C	D
BlueCare Quad Option 4	**BlueCare GoldSG 1000/25** *Gold level*	**BlueCare GoldSG 2000/25** *Gold level*	**BlueCare SilverSG 3100/35** *Silver level*	**BlueCare SilverSG HDHP 6000/0[§]** *Silver level*
Deductible	$1,000 / $2,000	$2,000 / $4,000	$3,100 / $6,200	$6,000 / $12,000
Coinsurance (% paid by member)	30%	30%	40%	0%
Annual out-of-pocket maximum	$6,600 / $13,200	$6,000 / $12,000	$9,200 / $18,400	$6,000 / $12,000
Home and office visits – Primary	$25	$25	$35 for 3 visits[†]	Subject to deductible
Home and office visits – Specialists	$50	$50	$70	Subject to deductible
	Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.			Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.
Emergency room	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Inpatient hospital services *Requires pre-admission certification*	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Preventive care	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share	$0 – Preventive is without cost share
Immunizations	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient lab, radiology and advanced imaging	$300 paid at 100% then subject to deductible/coinsurance	$300 paid at 100% then subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Prescription drugs – retail*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	Subject to deductible
Mail order drugs**	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4	Subject to deductible
Pediatric dental (ages 0-19)	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible/coinsurance	Cleanings and periodic evaluations covered at 100%, then subject to deductible
Pediatric vision (ages 0-19)	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Eye exams subject to office visit – specialists benefits, all other services subject to deductible/coinsurance	Subject to deductible
Outpatient rehabilitation	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient habilitative	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Outpatient surgery	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Mental illness/substance use disorders - outpatient services	$25	$25	$35 for 3 visits [†]	Subject to deductible
Home social work visits	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible/coinsurance	Subject to deductible
Change for 2025				

[†] Subject to deductible / coinsurance after copay
* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.
** Specialty drugs are not covered
[§] HSA compliant

BlueCare EPO BronzeSG 5000/25

2025 Plan Year – Expanded Bronze level

General	In-Network	Out-of-Network
Deductible	$5,000 per person / $10,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	50%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$8,750 per person / $17,500 per family	
Doctor's office visits		
Home and office visits – Primary	$25 copay for the first visit, then subject to deductible and 50% coinsurance	
Home and office visits – Specialists	Deductible then 50% coinsurance	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs	Deductible then 50% coinsurance	
Mail order drugs	Deductible then 50% coinsurance **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Inpatient surgery physician/surgical	Deductible then 50% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 50% coinsurance	
Outpatient surgery physician/surgical	Deductible then 50% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 50% coinsurance	
Emergency Room	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Injections	Deductible then 50% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits; all other services: Deductible then 50% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 50% coinsurance	
Outpatient habilitation	Deductible then 50% coinsurance	
Hospice	Deductible then 50% coinsurance	
Home social work visits	Deductible then 50% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 50% coinsurance	
Mental illness/substance use disorders – outpatient services	$0. Mental health, behavioral health and substance use services are without cost share.	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

BlueCare EPO BronzeSG HDHP 7100/0

2025 Plan Year – Expanded Bronze level

General	In-Network	Out-of-Network
Deductible	$7,100 per person / $14,200 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	0%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$7,100 per person / $14,200 family	
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	
Home and office visits – Specialists	Deductible then $0	
Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs	Deductible then $0	
Mail order drugs	Deductible then $0 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then $0	Deductible then $0
Inpatient surgery physician/surgical	Deductible then $0	
Inpatient facility fee *Requires pre-admission certification*	Deductible then $0	
Outpatient surgery physician/surgical	Deductible then $0	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then $0	
Emergency Room	Deductible then $0	Deductible then $0
Injections	Deductible then $0	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0	
Pediatric vision (for ages 0-19)	Deductible then $0	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then $0	
Outpatient habilitation	Deductible then $0	
Hospice	Deductible then $0	
Home social work visits	Deductible then $0	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then $0	
Mental illness/substance use disorders – outpatient services	Deductible then $0	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	Yes	
Change for 2025		

BlueCare EPO SilverSG HDHP 5100/0

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$5,100 per person / $10,200 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	0%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$5,100 per person / $10,200 family	
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	
Home and office visits – Specialists	Deductible then $0	
Telemedicine is subject to the same cost sharing provisions as a non-telemedicine service.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs	Deductible then $0	
Mail order drugs	Deductible then $0 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then $0	Deductible then $0
Inpatient surgery physician/surgical	Deductible then $0	
Inpatient facility fee *Requires pre-admission certification*	Deductible then $0	
Outpatient surgery physician/surgical	Deductible then $0	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then $0	
Emergency Room	Deductible then $0	Deductible then $0
Injections	Deductible then $0	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then $0	
Pediatric vision (for ages 0-19)	Deductible then $0	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then $0	
Outpatient habilitation	Deductible then $0	
Hospice	Deductible then $0	
Home social work visits	Deductible then $0	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then $0	
Mental illness/substance use disorders – outpatient services	Deductible then $0	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	Yes	
Change for 2025		

BlueCare EPO SilverSG 3100/35

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$3,100 per person / $6,200 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	40%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$9,200 per person / $18,400 family	
Doctor's office visits		
Home and office visits – Primary	$35 copay for 3 visits, then subject to deductbile and 40% coinsurance	
Home and office visits – Specialists	$70 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Inpatient surgery physician/surgical	Deductible then 40% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 40% coinsurance	
Outpatient surgery physician/surgical	Deductible then 40% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 40% coinsurance	
Emergency Room	Deductible then 40% coinsurance	Deductible then 40% coinsurance
Injections	Deductible then 40% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 40% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits; all other services: Deductible then 40% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 40% coinsurance	
Outpatient habilitation	Deductible then 40% coinsurance	
Hospice	Deductible then 40% coinsurance	
Home social work visits	Deductible then 40% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 40% coinsurance	
Mental illness/substance use disorders – outpatient services	$35 copay for 3 visits, then subject to deductbile and 40% coinsurance	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare EPO SilverSG 3000/35

2025 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$3,000 per person / $6,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	50%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$9,200 per person / $18,400 family	
Doctor's office visits		
Home and office visits – Primary	$35 copay per visit	
Home and office visits – Specialists	$70 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Inpatient surgery physician/surgical	Deductible then 50% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 50% coinsurance	
Outpatient surgery physician/surgical	Deductible then 50% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 50% coinsurance	
Emergency Room	Deductible then 50% coinsurance	Deductible then 50% coinsurance
Injections	Deductible then 50% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 50% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit - specialist benefits, all other services: Deductible then 50% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 50% coinsurance	
Outpatient habilitation	Deductible then 50% coinsurance	
Hospice	Deductible then 50% coinsurance	
Home social work visits	Deductible then 50% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 50% coinsurance	
Mental illness/substance use disorders – outpatient services	$35 copay per visit	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare EPO GoldSG 1500/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$1,500 per person / $3,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	20%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$4,950 per person / $9,900 family	
Doctor's office visits		
Home and office visits – Primary & Telemedicine	$25 copay for first 5 visits, then subject to deductible and 20% coinsurance	
Home and office visits – Specialists	$50 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Inpatient surgery physician/surgical	Deductible then 20% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 20% coinsurance	
Outpatient surgery physician/surgical	Deductible then 20% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	
Emergency Room	$300 copay then subject to deductbile and 20% coinsurance	$300 copay then subject to deductbile and 20% coinsurance
Injections	Deductible then 20% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit – specialist benefits; all other services: Deductible then 20% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 20% coinsurance	
Outpatient habilitation	Deductible then 20% coinsurance	
Hospice	Deductible then 20% coinsurance	
Home social work visits	Deductible then 20% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 20% coinsurance	
Mental illness/substance use disorders – outpatient services	$25 copay per visit	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare EPO GoldSG 1000/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$1,000 per person / $2,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	30%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$6,600 per person / $13,200 family	
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	
Home and office visits – Specialists	$50 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Inpatient surgery physician/surgical	Deductible then 30% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 30% coinsurance	
Outpatient surgery physician/surgical	Deductible then 30% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 30% coinsurance	
Emergency Room	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Injections	Deductible then 30% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 30% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit - specialist benefits, all other services: Deductible then 30% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 30% coinsurance	
Outpatient habilitation	Deductible then 30% coinsurance	
Hospice	Deductible then 30% coinsurance	
Home social work visits	Deductible then 30% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 30% coinsurance	
Mental illness/substance use disorders – outpatient services	$25 copay per visit	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare EPO GoldSG 2000/25

2025 Plan Year – Gold level

General	In-Network	Out-of-Network
Deductible	$2,000 per person / $4,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	30%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$6,000 per person / $12,000 family	
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	
Home and office visits – Specialists	$50 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Inpatient surgery physician/surgical	Deductible then 30% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 30% coinsurance	
Outpatient surgery physician/surgical	Deductible then 30% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 30% coinsurance	
Emergency Room	Deductible then 30% coinsurance	Deductible then 30% coinsurance
Injections	Deductible then 30% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 30% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit - specialist benefits, all other services: Deductible then 30% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 30% coinsurance	
Outpatient habilitation	Deductible then 30% coinsurance	
Hospice	Deductible then 30% coinsurance	
Home social work visits	Deductible then 30% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 30% coinsurance	
Mental illness/substance use disorders – outpatient services	$25 copay per visit	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

BlueCare EPO PlatinumSG 500/25

2025 Plan Year – Platinum level

General	In-Network	Out-of-Network
Deductible	$500 per person / $1,000 family	Out-of-Network services are not available, except services for medical emergencies and covered services not available in-network.
Coinsurance (percentage paid by member)	20%	
Coinsurance maximum	Same as the annual out-of-pocket max	
Annual out-of-pocket maximum	$1,500 per person / $3,000 family	
Doctor's office visits		
Home and office visits – Primary	$25 copay per visit	
Home and office visits – Specialists	$50 copay per visit	
Telemedicine: Virtual visits by AmWell and non-AmWell in-network providers are covered at 100%.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs*	$10 Tier 1 / $30 Tier 2/ $65 Tier 3 / $100 Tier 4 / Deductible then 25% up to $500 Tier 5 & 6	
Mail order drugs*	$25 Tier 1 / $75 Tier 2 / $162.50 Tier 3 / $250 Tier 4 **Specialty drugs are not covered**	
Medical services		
Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Inpatient surgery physician/surgical	Deductible then 20% coinsurance	
Inpatient facility fee *Requires pre-admission certification*	Deductible then 20% coinsurance	
Outpatient surgery physician/surgical	Deductible then 20% coinsurance	
Outpatient lab and radiology and advanced imaging (CT/PET scans, MRIs)	$300 paid at 100%, then subject to deductible, then 20% coinsurance	
Emergency Room	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Injections	Deductible then 20% coinsurance	
Dental and Vision		
Pediatric dental (for ages 0-19)	Cleanings and periodic evaluations covered at 100% – other services: Deductible then 20% coinsurance	
Pediatric vision (for ages 0-19)	Eye exams subject to office visit - specialist benefits, all other services: Deductible then 20% coinsurance	
Recovery/Special Needs		
Outpatient rehabilitation	Deductible then 20% coinsurance	
Outpatient habilitation	Deductible then 20% coinsurance	
Hospice	Deductible then 20% coinsurance	
Home social work visits	Deductible then 20% coinsurance	
Mental Illness/Substance Use Disorders		
Mental illness/substance use disorders – inpatient services Requires pre-admission certification from Lucet™ behavioral health at 800-952-5906	Deductible then 20% coinsurance	
Mental illness/substance use disorders – outpatient services	$25 copay per visit	
Other		
Lifetime maximum	Unlimited for each covered person	
Eligible dependents	Covered to age 26	
HSA compliant	No	
Change for 2025		

* Drug classifications have been renamed from Generic, Brand, and Specialty to Tiers. Please refer to the drug list to determine the tier of your prescription drug.

Glossary

Allowed amount
The amount Blue Cross determines as the maximum amount paid for the medical service provided.

Coinsurance
Coinsurance is your share of the cost of a covered medical service after you've met your deductible for your benefit period.

Copayment or copay
A copayment is the set dollar amount you pay (for example, the $20 you pay when you check out at the doctor's office) for medical services or prescription drugs at the time you receive them.

Deductible
A deductible is the set dollar amount you pay toward covered medical services each benefit period before Blue Cross starts paying toward those services.

Explanation of benefits (EOB)
You receive an EOB after a visit to a doctor, health care provider, pharmacy or facility. An EOB lists details of the medical service received including date, amounts paid by Blue Cross, and the cost you may owe.

In-network providers
In-network providers are health care providers and facilities that contract with Blue Cross or participate in the BlueCard program. You may pay less if you see an in-network provider.

Out-of-pocket maximum
The maximum dollar amount you pay for covered services in a benefit period before Blue Cross pays 100% of covered services. It includes your deductible, coinsurance and copayments.

Exclusions

Following is a list of common non-covered services. For a complete list of limitations and exclusions, refer to your contract or certificate.

Services involving cosmetic or reconstructive surgery (except as stated in the contract or certificate); charges for personal items; convalescent or custodial care or rest care; all keratotomy procedures; blood or payments to donors of blood; services related to the reversal of sterilization procedures; any medically-aided insemination procedure; charges for services by immediate relatives or by members of the household; acupuncture and admission for acupuncture; medically unnecessary services and admissions; Health services associated with accidental bodily injuries arising from a motor vehicle accident to the extent such services are payable under a medical expense payment provision of any automobile insurance policy; services, supplies or treatments not specifically listed as covered in the member's contract or certificate.

Drug coverage limitation: Generic drugs are mandatory if available unless physician prescribes a brand drug.

Specialty drug coverage: In-network benefits are applied when specialty drugs are obtained from our designated specialty pharmacy.

This brochure provides a brief description of some important features and exclusions of this benefit program. It is not a legal document. The certificate or contract sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Kansas.

Contact us

We are available 8 a.m. to 4:30 p.m.
Monday through Friday.

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