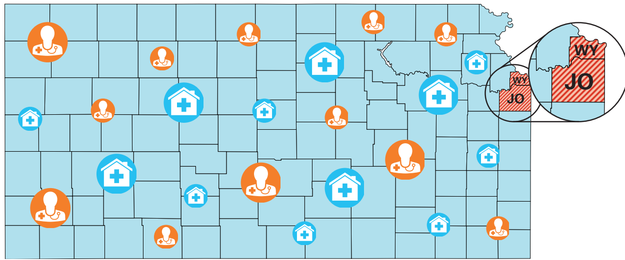
2024 Plan Year

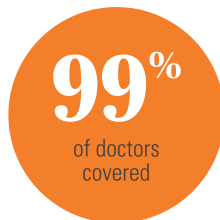
Access to your benefits

BlueCare EPO plans will access the Solutions provider network that has you covered throughout our 103-county coverage area (excluding Johnson and Wyandotte) within the state of Kansas.



Please remember, you have no coverage for services provided outside of the provider network with the exception of medical emergencies. If you receive services from an out-of-network doctor or other healthcare provider, you will be held responsible to pay all of the costs for the services.

In Kansas, these are our impressive numbers:



You have choices

The provider network allows you access to your choice of:

- Medical providers
- Preventive care providers
- Pharmacy locations

Referrals

See the specialist you prefer within the Solutions provider network without having to see a primary care physician (PCP) first.

Referrals to a provider outside of the network cannot be made by your doctor or hospital. **Referrals to non-network providers must be approved by Blue Cross and Blue Shield of Kansas** and are only considered when the services are not available from an in-network provider. Out-of-network providers are those that do not contract inside the state and all providers outside of our 103-county coverage area within the state of Kansas.

Emergency coverage

If emergency care is needed – even outside of the Solutions provider network – you can go to the nearest hospital and still receive the maximum benefits of your plan.

Exclusions

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

Duplicate benefits provided under federal, state or local laws, regulations or programs except Medicaid; services involving cosmetic or reconstructive surgery (except as stated in the contract); 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; services covered and payable under any medical expense payment provision of any automobile insurance policy; mental illness or substance use disorder services provided by a non-eligible provider; services, supplies or treatments not specifically listed as covered in the member's contract.

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 contract sets forth in detail the rights and obligations of you and Blue Cross and Blue Shield of Kansas.

Visit us at bcbsks.com

BlueCross BlueShield Kansas

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BCS419d 09/23

An independent licensee of the Blue Cross Blue Shield Association.

BlueCare EPO Simple Silver 3

2024 Plan Year – Silver level

General	In-Network	Out-of-Network
Deductible	$400 per person / $800 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	$900 per person / $1,800 family	
Doctor's office visits		
Home and office visits – Primary	Deductible then $0	
Home and office visits – Specialists	Deductible then $0	
Telemedicine: AmWell virtual visit is the same cost share as a primary office visit. Virtual visit with a non-AmWell provider is the same cost share as an in-person visit.		
Preventive care	$0 – Preventive is without cost share	
Prescription drug coverage		
Prescription drugs	Subject to deductible preferred and non-preferred generics; subject to deductible then $50 copay brand; All others are subject to deductible then 50% coinsurance	
Mail order drugs	Subject to deductible preferred and non-preferred generics; Subject to deductible then $125 copay Brand; Deductible then 50% coinsurance non-preferred **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	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	No	

Change for 2024