BlueCross BlueShield of Illinois

2024

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

All Blue Cross and Blue Shield of Illinois (BCBSIL) plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit **bcbsil.com** for more specific information.

Gold	Blue Precision Gold HMO℠ [2]		
	207	703 - Rx Copays	707
Individual Deductible [3]	$750	$2,000	$1,500
Coinsurance	30%	30%	25%
Out-of-Pocket Maximum (includes deductible) [3]	$9,450	$9,450	$8,700
Primary Care Office Visit	$20 copay	$40 copay	$30 copay
Specialist Office Visit	$40 copay	$60 copay	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$20 copay	$40 copay	$30 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	$1,000 per occurrence deductible, then 30%	25%
Urgent Care	$40 copay	$60 copay	$45 copay
Inpatient Hospital Services	$750 per day copay	$750 copay per day	25%
Outpatient Surgery [4]	$300 per occurrence deductible, then 30%	$300 per occurrence deductible, then 30%	25%
X-Rays and Diagnostic Imaging [4]	$40 copay	$40 copay	25%
Imaging (CT/PET Scans/MRIs) [4]	$250 copay	$250 copay	25%
Network	Blue Precision HMO℠	Blue Precision HMO℠	Blue Precision HMO℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [5]	10% / 15% / 20% / 30% / 40% / 50% [6]	$20 / $30 / $60 / $120 / $250 / $350 [6]	$15 / $30 / $60 / $250 [7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [5]	10% / 15% / 20% / 30% / 40% / 50% [6]	$20 / $30 / $60 / $120 / $250 / $350 [6]	$15 / $30 / $60 / $250 [7]
Prescription Drug Benefit Utilization Management Programs [8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.		

1 Benefits reduced when out-of-network providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 **Blue Precision HMO℠ plans are available only in the Chicago, Peoria and Rockford metro areas.**

3 The standard deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Note that copays apply whether or not you have met the deductible.

4 Members may have lower out-of-pocket costs for some services provided by freestanding non-emergency outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.

5 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescription drugs with a lower possible member cost-share amount. Preferred pharmacy pricing is not available with HMO plans.

6 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

7 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.

8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.

BlueCross BlueShield of Illinois

2024

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

All Blue Cross and Blue Shield of Illinois (BCBSIL) plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit **bcbsil.com** for more specific information.

Gold	Blue Choice Preferred Gold PPO℠		Blue FocusCare Gold℠ [2]
	204 - Rx Copays	707	211
Individual Deductible [3]	$750	$1,500	$750
Coinsurance	30%	25%	30%
Out-of-Pocket Maximum (includes deductible) [3]	$9,450	$8,700	$9,450
Primary Care Office Visit	$15 copay	$30 copay	$20 copay
Specialist Office Visit	30%	$60 copay	$40 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	30%	$30 copay	$20 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	25%	$1,000 per occurrence deductible, then 30%
Urgent Care	$25 copay	$45 copay	$40 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 30%	25%	$750 per day copay
Outpatient Surgery [4]	30%	25%	$300 per occurrence deductible, then 30%
X-Rays and Diagnostic Imaging [4]	30%	25%	$40 copay
Imaging (CT/PET Scans/MRIs) [4]	30%	25%	$250 copay
Network	Blue Choice Preferred PPO℠	Blue Choice Preferred PPO℠	Blue FocusCare℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [5]	$20 / $30 / $60 / $120 / $250 / $350 [6]	$15 / $30 / $60 / $250 [7]	10% / 15% / 20% / 30% / 40% / 50% [6]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [5]	$20 / $30 / $60 / $120 / $250 / $350 [6]	$15 / $30 / $60 / $250 [7]	10% / 15% / 20% / 30% / 40% / 50% [6]
Prescription Drug Benefit Utilization Management Programs [8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.		

1 Benefits reduced when out-of-network providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 **Blue FocusCare℠ plans are available only in Cook County.**

3 The standard deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Note that copays apply whether or not you have met the deductible.

4 Members may have lower out-of-pocket costs for some services provided by freestanding non-emergency outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.

5 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescription drugs with a lower possible member cost-share amount. Preferred pharmacy pricing is not available with HMO plans.

6 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

7 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.

8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.

BlueCross BlueShield of Illinois

2024

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

All Blue Cross and Blue Shield of Illinois (BCBSIL) plans provide coverage for preventive services and maternity care. Please see your Summary of Benefits and Coverage or visit **bcbsil.com** for more specific information.

Gold	BlueCare Direct Gold℠ with Advocate[2]	
	409 - Rx Copays	**804**
Individual Deductible[3]	$2,000	$1,500
Coinsurance	30%	25%
Out-of-Pocket Maximum (includes deductible)[3]	$9,450	$8,700
Primary Care Office Visit	$40 copay	$30 copay
Specialist Office Visit	$60 copay	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$40 copay	$30 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	25%
Urgent Care	$60 copay	$45 copay
Inpatient Hospital Services	$750 per day copay	25%
Outpatient Surgery[4]	$300 per occurrence deductible, then 30%	25%
X-Rays and Diagnostic Imaging[4]	$40 copay	25%
Imaging (CT/PET Scans/MRIs)[4]	$250 copay	25%
Network	BlueCare Direct℠	BlueCare Direct℠
HSA Eligible	No	No
Outpatient Prescription Drugs - Preferred Pharmacy[5]	$20 / $30 / $60 / $120 / $250 / $350[6]	$15 / $30 / $60 / $250[7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[5]	$20 / $30 / $60 / $120 / $250 / $350[6]	$15 / $30 / $60 / $250[7]
Prescription Drug Benefit Utilization Management Programs[8]	**Specialty Pharmacy Program:** To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider. **Member Pay the Difference:** When you choose a brand name drug over an available generic equivalent, you pay your usual share for the brand plus the difference in cost. **Prior Authorization/Step Therapy Requirements:** Before you receive coverage for some medications, your doctor may need to obtain authorization from BCBSIL. You may need to meet certain criteria or try more cost-effective drugs first. **90-Day Supply:** You may receive up to a 90-day supply of covered prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.	

1 Benefits reduced when out-of-network providers are used. This is a summary of benefit highlights only. All benefits shown represent what the member would pay.

2 Advocate Health Care is an independently contracted provider. **BlueCare Direct℠ plans are available only in parts of the Chicago metro area.**

3 The standard deductible and out-of-pocket maximum for this plan are shown. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Note that copays apply whether or not you have met the deductible.

4 Members may have lower out-of-pocket costs for some services provided by freestanding non-emergency outpatient facilities than the out-of-pocket costs for services provided in a hospital setting. See your Summary of Benefits and Coverage for additional details.

5 Prescription drug benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescription drugs with a lower possible member cost-share amount. Preferred pharmacy pricing is not available with HMO plans.

6 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

7 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.

8 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply. Coverage limitations may apply to certain medications.

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.