



Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

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

| Bronze | BlueCare Direct Bronze SM with Advocate ² |
|---|--|
| | Standard - Select Rx Copays |
| Individual Deductible ³ | \$7,500 |
| Coinsurance | 50% |
| Out-of-Pocket Maximum (includes deductible) ³ | \$10,000 |
| Primary Care Office Visit | \$50 copay |
| Specialist Office Visit | \$100 copay |
| Mental Illness Treatment and Substance Use Disorder Rehabilitation Office Visit | \$50 copay |
| Emergency Room | 50% |
| Urgent Care | \$75 copay |
| Inpatient Hospital Services | 50% |
| Outpatient Hospital Services | 50% |
| Outpatient X-Rays and Diagnostic Imaging | 50% |
| Outpatient Imaging (CT/PET Scans/MRIs) | 50% |
| Network | BlueCare Direct SM |
| HSA Eligible ⁴ | Yes |
| Outpatient Prescription Drugs - Preferred Pharmacy ⁵ | \$25 / \$50 / \$100 / \$500 ⁶ |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ⁵ | \$25 / \$50 / \$100 / \$500 ⁶ |
| Prescription Drug Benefit Utilization Management Programs ⁷ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider.</p> <p>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.</p> <p>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.</p> <p>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.</p> |

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 DirectSM is 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 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Illinois does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the

transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.
 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 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty, Brands and some Generics. Costs are for outpatient prescriptions through a preferred pharmacy. Deductible may apply to certain tiers. See your Summary of Benefits and Coverage for details.
 7 Home delivery is not available for Specialty tier drugs. Specialty tier drugs are limited to a 30-day supply in most cases. Coverage limitations may apply to certain medications.



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

| Bronze | Blue Choice Preferred Bronze PPO SM | | | |
|---|--|--|---|--|
| | 201 | 202 ² | 701 | Standard - Select Rx Copays |
| Individual Deductible ³ | \$7,000 | \$4,500 | \$8,600 | \$7,500 |
| Coinsurance | 50% | 40% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible) ³ | \$10,150 | \$8,300 | \$10,600 | \$10,000 |
| Primary Care Office Visit | \$45 copay | 40% | 50% | \$50 copay |
| Specialist Office Visit | 50% | 40% | 50% | \$100 copay |
| Mental Illness Treatment and Substance Use Disorder Rehabilitation Office Visit | 50% | 40% | 50% | \$50 copay |
| Emergency Room | 50% | 40% | 50% | 50% |
| Urgent Care | \$60 copay | 40% | 50% | \$75 copay |
| Inpatient Hospital Services | 50% | 40% | 50% | 50% |
| Outpatient Hospital Services | \$600 per occurrence deductible, then 40% | \$600 per occurrence deductible, then 30% | \$600 per occurrence deductible, then 40% | 50% |
| Outpatient X-Rays and Diagnostic Imaging | 40% | 30% | 40% | 50% |
| Outpatient Imaging (CT/PET Scans/MRIs) | 40% | 30% | 40% | 50% |
| Network | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM | Blue Choice Preferred PPO SM |
| HSA Eligible ⁴ | Yes | Yes | Yes | Yes |
| Outpatient Prescription Drugs - Preferred Pharmacy ⁵ | \$10 / \$20 / 30% / 35% / 45% / 50% ⁶ | 20% / 25% / 30% / 35% / 45% / 50% ⁶ | \$25 / \$175 / 30% / 40% / 45% / 50% ⁶ | \$25 / \$50 / \$100 / \$500 ⁷ |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ⁵ | \$20 / \$30 / 35% / 40% / 45% / 50% ⁶ | 25% / 30% / 35% / 40% / 45% / 50% ⁶ | \$35 / \$175 / 30% / 40% / 45% / 50% ⁶ | \$25 / \$50 / \$100 / \$500 ⁷ |
| Prescription Drug Benefit Utilization Management Programs⁸ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | | |

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 This plan is not available on Get Covered Illinois.
 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 As a reminder, a Health Savings Account (HSA) has tax and legal ramifications. Blue Cross and Blue Shield of Illinois does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax adviser regarding tax consequences of specific health insurance plans or products.

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 / Specialty, Preferred Brand, and some Generics / Specialty, Non-Preferred Brand, and some Generics.
 7 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty, Brands and some Generics. 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 in most cases. Coverage limitations may apply to certain medications.



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| Bronze | Blue Precision Bronze HMO ^{SM 2} | | |
|---|--|---|--|
| | 205 | 701 | Standard - Select Rx Copays |
| Individual Deductible ³ | \$7,400 | \$4,500 | \$7,500 |
| Coinsurance | 50% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible) ³ | \$10,600 | \$10,150 | \$10,000 |
| Primary Care Office Visit | \$65 copay | \$50 copay | \$50 copay |
| Specialist Office Visit | \$105 copay | \$120 copay | \$100 copay |
| Mental Illness Treatment and Substance Use Disorder Rehabilitation Office Visit | \$65 copay | \$50 copay | \$50 copay |
| Emergency Room | 50% | 50% | 50% |
| Urgent Care | \$105 copay | \$120 copay | \$75 copay |
| Inpatient Hospital Services | 50% | 50% | 50% |
| Outpatient Hospital Services | \$300 per occurrence deductible, then 50% | \$750 per occurrence deductible, then 50% | 50% |
| Outpatient X-Rays and Diagnostic Imaging | \$150 copay | \$250 copay | 50% |
| Outpatient Imaging (CT/PET Scans/MRIs) | \$300 copay | \$450 copay | 50% |
| Network | Blue Precision HMO SM | Blue Precision HMO SM | Blue Precision HMO SM |
| HSA Eligible ⁴ | Yes | Yes | Yes |
| Outpatient Prescription Drugs - Preferred Pharmacy ⁵ | 10% / 15% / 20% / 30% / 40% / 50% ⁶ | \$15 / \$150 / 35% / 40% / 45% / 50% ⁶ | \$25 / \$50 / \$100 / \$500 ⁷ |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ⁵ | 10% / 15% / 20% / 30% / 40% / 50% ⁶ | \$15 / \$150 / 35% / 40% / 45% / 50% ⁶ | \$25 / \$50 / \$100 / \$500 ⁷ |

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.

Prescription Drug Benefit Utilization Management Programs⁸

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 HMOSM 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.

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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 / Specialty, Preferred Brand, and some Generics / Specialty, Non-Preferred Brand, and some Generics.

7 Four prescription drug payment level tiers: Generic / Preferred Brand / Non-Preferred Brand / Specialty, Brands and some Generics. 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 in most cases. Coverage limitations may apply to certain medications.



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| Bronze | MyBlue Plus Bronze ^{SM 2} | | |
|---|--|---|---|
| | 903 | 912 | Standard - Select Rx Copays |
| Individual Deductible ³ | \$4,000 | \$1,500 | \$7,500 |
| Coinsurance | 50% | 50% | 50% |
| Out-of-Pocket Maximum (includes deductible) ³ | \$9,500 | \$10,000 | \$10,000 |
| Primary Care Office Visit | \$20 copay | \$30 copay | \$50 copay |
| Specialist Office Visit | 50% | \$140 copay | \$100 copay |
| Mental Illness Treatment and Substance Use Disorder Rehabilitation Office Visit | 50% | \$30 copay | \$50 copay |
| Emergency Room | 50% | 50% | 50% |
| Urgent Care | \$60 copay | \$150 copay | \$75 copay |
| Inpatient Hospital Services | 50% | 50% | 50% |
| Outpatient Hospital Services | \$600 per occurrence deductible, then 50% | \$750 per occurrence deductible, then 50% | 50% |
| Outpatient X-Rays and Diagnostic Imaging | 50% | \$250 copay | 50% |
| Outpatient Imaging (CT/PET Scans/MRIs) | 50% | \$450 copay | 50% |
| Network | MyBlue Plus SM | MyBlue Plus SM | MyBlue Plus SM |
| HSA Eligible ⁴ | Yes | Yes | Yes |
| Outpatient Prescription Drugs - Preferred Pharmacy ⁵ | 0% / 10% / 20% / 35% / 45% / 50% ⁶ | \$40 / \$150 / 35% / 40% / 45% / 50% ⁶ | \$25/ \$50 / \$100 / \$500 ⁷ |
| Outpatient Prescription Drugs - Non-Preferred Pharmacy ⁵ | 0% / 10% / 20% / 35% / 45% / 50% ⁶ | \$40 / \$150 / 35% / 40% / 45% / 50% ⁶ | \$25/ \$50 / \$100 / \$500 ⁷ |
| Prescription Drug Benefit Utilization Management Programs⁸ | <p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through a preferred Specialty Pharmacy provider.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | |

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2 MyBlue PlusSM plans are available only in the following counties: Cook, DuPage, Kane, Kankakee and Will.

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.

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Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language 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, you can file a grievance with:

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

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: civilrightscordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal:
ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms:
hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

| | |
|--------------------|--|
| Español Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor. |
| العربية Arabic | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |

bcbsil.com



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|---------------------|---|
| 中文 Chinese | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。 |
| Français French | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur. |
| Deutsch German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिंदी Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। |
| Italiano Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore. |
| 한국어 Korean | 주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. |
| Diné Navajo | SHOOH: Diné bee yáníłt'ígogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólǫ́. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoót'ígíí éí t'áá jiik'eh hólǫ́. Kohjí' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih. |
| فارسی Farsi | توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید. |
| Polski Polish | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą. |
| РУССКИЙ Russian | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг. |
| Tagalog Tagalog | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو Urdu | توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ |
| Việt Vietnamese | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. |

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