BlueCross BlueShield of Illinois

2025

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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.

Gold	Blue Choice Preferred Gold PPO℠		
	204	901	Standard - Rx Copays
Individual Deductible[2]	$750	$1,000	$1,500
Coinsurance	30%	30%	25%
Out-of-Pocket Maximum (includes deductible)[2]	$9,200	$9,200	$7,800
Primary Care Office Visit	$15 copay	$5 copay	$30 copay
Specialist Office Visit	30%	$45 copay	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	30%	$5 copay	$30 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	$1,000 per occurrence deductible, then 30%	25%
Urgent Care	$25 copay	$45 copay	$45 copay
Inpatient Hospital Services	$850 per occurrence deductible, then 30%	$850 per occurrence deductible, then 30%	25%
Outpatient Surgery[3]	30%	30%	25%
X-Rays and Diagnostic Imaging[3]	30%	30%	25%
Imaging (CT/PET Scans/MRIs)[3]	30%	30%	25%
Network	Blue Choice Preferred PPO℠	Blue Choice Preferred PPO℠	Blue Choice Preferred PPO℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy[4]	$0 / $10 / 20% / 35% / 45% / 50%[5]	$5 / $10 / $50 / 35% / 45% / 50%[5]	$15 / $30 / $60 / $250[6]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[4]	$10 / $20 / 30% / 40% / 45% / 50%[5]	$10 / $20 / $60 / 40% / 45% / 50%[5]	$15 / $30 / $60 / $250[6]
Prescription Drug Benefit Utilization Management Programs[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.		

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 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.
3 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.
4 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.
5 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty.
6 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.
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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BlueCross BlueShield of Illinois

2025

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Gold	BlueCare Direct Gold℠ with Advocate[2]
	Standard - Rx Copays
Individual Deductible[3]	$1,500
Coinsurance	25%
Out-of-Pocket Maximum (includes deductible)[3]	$7,800
Primary Care Office Visit	$30 copay
Specialist Office Visit	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$30 copay
Emergency Room	25%
Urgent Care	$45 copay
Inpatient Hospital Services	25%
Outpatient Surgery[4]	25%
X-Rays and Diagnostic Imaging[4]	25%
Imaging (CT/PET Scans/MRIs)[4]	25%
Network	BlueCare Direct℠
HSA Eligible	No
Outpatient Prescription Drugs - Preferred Pharmacy[5]	$15 / $30 / $60 / $250[6]
Outpatient Prescription Drugs - Non-Preferred Pharmacy[5]	$15 / $30 / $60 / $250[6]
Prescription Drug Benefit Utilization Management Programs[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.

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 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.

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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2025

Individual Plan Comparison Chart

Participating Provider Coverage Shown[1]

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Gold	Blue Precision Gold HMO℠ [2]		
	207	703	Standard - Rx Copays
Individual Deductible [3]	$750	$1,500	$1,500
Coinsurance	30%	30%	25%
Out-of-Pocket Maximum (includes deductible) [3]	$9,200	$9,200	$7,800
Primary Care Office Visit	$20 copay	$15 copay	$30 copay
Specialist Office Visit	$40 copay	$60 copay	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$20 copay	$15 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	$30 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]	$0 / $20 / 20% / 30% / 40% / 50% [6]	$15 / $30 / $60 / $250 [7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [5]	10% / 15% / 20% / 30% / 40% / 50% [6]	$0 / $20 / 20% / 30% / 40% / 50% [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, in most cases. Coverage limitations may apply to certain medications.

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2025

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Gold	MyBlue Plus Gold℠ [2]		
	909	910	Standard - Rx Copays
Individual Deductible [3]	$1,500	$250	$1,500
Coinsurance	30%	40%	25%
Out-of-Pocket Maximum (includes deductible) [3]	$9,200	$7,500	$7,800
Primary Care Office Visit	$15 copay	20%	$30 copay
Specialist Office Visit	$60 copay	40%	$60 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	$15 copay	20%	$30 copay
Emergency Room	$1,000 per occurrence deductible, then 30%	$1,000 per occurrence deductible, then 40%	25%
Urgent Care	$60 copay	40%	$45 copay
Inpatient Hospital Services	$750 per day	$850 per occurrence deductible, then 40%	25%
Outpatient Surgery [4]	$300 per occurrence deductible, then 30%	$600 per occurrence deductible, then 40%	25%
X-Rays and Diagnostic Imaging [4]	$30 copay	40%	25%
Imaging (CT/PET Scans/MRIs) [4]	$250 copay	40%	25%
Network	MyBlue Plus℠	MyBlue Plus℠	MyBlue Plus℠
HSA Eligible	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy [5]	$0 / $20 / 20% / 30% / 40% / 50% [6]	10% / 20% / 30% / 35% / 45% / 50% [6]	$15 / $30 / $60 / $250 [7]
Outpatient Prescription Drugs - Non-Preferred Pharmacy [5]	$0 / $20 / 20% / 30% / 40% / 50% [6]	10% / 20% / 30% / 35% / 45% / 50% [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 MyBlue Plus℠ 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.

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.

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BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

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	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	
Washington, DC 20201	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.

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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 Sprachassistenzdienste 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 Gujurati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क 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 yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده 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.
اردو Urdu	توجہ 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۔ (TTY: 711 855-710-6984) 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.