



Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

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 SM	Blue Choice Preferred Gold PPO SM	Blue FocusCare Gold SM
	207	204	211 ²
Individual Deductible³	\$500	\$750	\$500
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum (includes deductible)³	\$7,900	\$7,900	\$7,900
Primary Care Office Visit	\$20 copay	\$15 copay	\$20 copay
Specialist Office Visit	\$40 copay	\$50 copay	\$40 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	\$20 copay	\$15 copay	\$20 copay
Emergency Room	\$1,000 per occurrence deductible, then 30%	\$1,000 per occurrence deductible, then 30%	\$1,000 per occurrence deductible, then 30%
Urgent Care	\$40 copay	\$50 copay	\$40 copay
Inpatient Hospital Services	\$750 per day copay	\$850 per occurrence deductible, then 30%	\$750 per day copay
Outpatient Surgery⁴	\$300 per occurrence deductible, then 50%	30%	\$300 per occurrence deductible, then 50%
X-Rays and Diagnostic Imaging⁴	\$40 copay	30%	\$40 copay
Imaging (CT/PET Scans/MRIs)⁴	\$500 copay	30%	\$500 copay
Network	Blue Precision HMO SM	Blue Choice Preferred PPO SM	Blue FocusCare SM
HSA Eligible⁵	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy^{6,7}	10%/15%/20%/30%/40%/50%	\$0/\$10/20%/35%/45%/50%	10%/15%/20%/30%/40%/50%
Outpatient Prescription Drugs - Non-Preferred Pharmacy^{6,7}	10%/15%/20%/30%/40%/50%	\$10/\$20/30%/40%/45%/50%	10%/15%/20%/30%/40%/50%
Prescription Drug Utilization Benefit Management Programs⁸	<p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the 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 plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor will need to receive authorization from BCBSIL. You may also need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive a 90-day supply of prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p>		

1 Benefits reduced when non-preferred providers are used. This is a summary of benefit highlights only. All benefits shown indicate member responsibility.

2 Blue FocusCareSM plans are available only in Ratings Area 1. Please see your benefit booklet for more information.

3 The standard per person 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. Deductibles do not apply to services for which only copays are charged.

4 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding 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 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.

6 Prescription benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible copay amount.

7 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

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.



Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

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.

Silver	Blue Precision Silver HMO SM		Blue Choice Preferred Silver PPO SM		Blue FocusCare Silver SM	BlueCare Direct Silver SM in Collaboration with Advocate Health Care [*]
	206	306 ²	203	303 ²	210 ³	212
Individual Deductible⁴	\$2,500	\$2,600	\$2,200	\$2,200	\$4,150	\$2,500
Coinsurance	50%	50%	50%	50%	30%	50%
Out-of-Pocket Maximum (includes deductible)⁴	\$7,900	\$7,900	\$7,900	\$7,900	\$7,900	\$7,900
Primary Care Office Visit	\$30 copay	\$10 copay	\$10 copay	\$10 copay	\$30 copay	\$30 copay
Specialist Office Visit	\$65 copay	\$20 copay	50%	50%	\$60 copay	\$65 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	\$30 copay	\$10 copay	50%	50%	\$30 copay	\$30 copay
Emergency Room	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 30%	\$1,000 per occurrence deductible, then 50%
Urgent Care	\$65 copay	\$20 copay	\$15 copay	\$15 copay	\$60 copay	\$65 copay
Inpatient Hospital Services⁵	\$500 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 50%	\$750 per day copay	\$500 per occurrence deductible, then 50%
Outpatient Surgery⁵	50%	\$600 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 50%	\$300 per occurrence deductible, then 50%	50%
X-Rays and Diagnostic Imaging⁵	\$20 copay	\$20 copay	50%	50%	\$100 copay	\$20 copay
Imaging (CT/PET Scans/MRIs)	\$250 copay	\$250 copay	50%	50%	\$500 copay	\$250 copay
Network	Blue Precision HMO SM	Blue Precision HMO SM	Blue Choice Preferred PPO SM	Blue Choice Preferred PPO SM	Blue FocusCare SM	BlueCare Direct SM
HSA Eligible⁶	No	No	No	No	No	No
Outpatient Prescription Drugs - Preferred Pharmacy^{7,8}	0%/10%/20%/30%/40%/50%	\$5/\$15/30%/35%/45%/50%	\$5/\$15/30%/35%/45%/50%	\$5/\$15/30%/35%/45%/50%	10%/15%/20%/30%/40%/50%	0%/10%/20%/30%/40%/50%
Outpatient Prescription Drugs - Non-Preferred Pharmacy^{7,8}	0%/10%/20%/30%/40%/50%	\$5/\$15/30%/35%/45%/50%	\$10/\$25/35%/40%/45%/50%	\$10/\$25/35%/40%/45%/50%	10%/15%/20%/30%/40%/50%	0%/10%/20%/30%/40%/50%
Prescription Drug Utilization Benefit Management Programs⁹	<p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the 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 plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor will need to receive authorization from BCBSIL. You may also need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive a 90-day supply of prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p>					

1 Benefits reduced when non-preferred providers are used. This is a summary of benefit highlights only. All benefits shown indicate member responsibility.

2 This plan is not available on the Health Insurance Marketplace in Illinois.

3 Blue FocusCareSM plans are available only in Rating Area 1. Please see your benefit booklet for more information.

4 The standard per person 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. Deductibles do not apply to services for which only copays are charged. Based on your income and family status you may qualify for one of three lower deductible levels. You will be able to see if you qualify and what your premium, deductible and out-of-pocket costs will be before you make a decision to enroll.

5 Members may have lower out-of-pocket costs for some services provided by non-emergency freestanding 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.

6 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.

7 Prescription benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible copay amount.

8 Prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty

9 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.

* Advocate Health Care is an independently contracted provider.



Individual Plan Comparison Chart

Participating Provider Coverage Shown¹

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.

Bronze	Blue Precision Bronze HMO SM	Blue Choice Preferred Bronze PPO SM			Blue FocusCare Bronze SM
	205	201 - Two \$40 PCP Visits	202	302*	209 ²
Individual Deductible ³	\$6,000	\$6,000	\$3,150	\$6,000	\$6,000
Coinsurance	40%	50%	40%	40%	40%
Out-of-Pocket Maximum (includes deductible) ³	\$7,900	\$7,900	\$6,650	\$6,650	\$7,900
Primary Care Office Visit	\$50 copay	\$40 for first two visits, then 50%	40%	40%	\$50 copay
Specialist Office Visit	\$85 copay	50%	40%	40%	\$85 copay
Mental Illness Treatment and Substance Abuse Rehabilitation Office Visit	\$50 copay	50%	40%	40%	\$50 copay
Emergency Room	\$1,000 per occurrence deductible, then 40%	\$1,000 per occurrence deductible, then 50%	\$1,000 per occurrence deductible, then 40%	\$1,000 per occurrence deductible, then 40%	\$1,000 per occurrence deductible, then 40%
Urgent Care	\$85 copay	\$60 copay	\$0	\$0	\$85 copay
Inpatient Hospital Services	\$850 copay	\$850 per occurrence deductible, then 50%	\$850 per occurrence deductible, then 40%	\$850 per occurrence deductible, then 40%	\$850 copay
Outpatient Surgery ⁴	\$300 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 50%	\$600 per occurrence deductible, then 40%	\$600 per occurrence deductible, then 40%	\$300 per occurrence deductible, then 50%
Outpatient X-Rays and Diagnostic Imaging ⁴	\$200 copay	50%	40%	40%	\$200 copay
Outpatient Imaging (CT/PET Scans/MRIs) ⁴	\$600 copay	50%	40%	40%	\$600 copay
Network	Blue Precision HMO SM	Blue Choice Preferred PPO SM	Blue Choice Preferred PPO SM	Blue Choice Preferred PPO SM	Blue FocusCare SM
HSA Eligible ⁵	No	No	Yes	Yes	No
Outpatient Prescription Drugs - Preferred Pharmacy ^{6,7}	10%/15%/20%/30%/40%/50%	\$10/\$20/30%/35%/45%/50%	20%/25%/30%/35%/45%/50%	20%/25%/30%/35%/45%/50%	10%/15%/20%/30%/40%/50%
Outpatient Prescription Drugs - Non-Preferred Pharmacy ^{6,7}	10%/15%/20%/30%/40%/50%	\$20/\$30/35%/40%/45%/50%	25%/30%/35%/40%/45%/50%	25%/30%/35%/40%/45%/50%	10%/15%/20%/30%/40%/50%
Prescription Drug Utilization Benefit Management Programs ⁸	<p>Specialty Pharmacy Program: To be eligible for maximum benefits, specialty medications must be obtained through the 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 plus the difference in cost.</p> <p>Prior Authorization/Step Therapy Requirements: Before you receive coverage for some medications, your doctor will need to receive authorization from BCBSIL. You may also need to meet certain criteria or try more cost-effective drugs first.</p> <p>90-Day Supply: You may receive a 90-day supply of prescription drugs through home delivery or at select retail pharmacies, depending on your prescription drug benefit.</p>				

1 Benefits reduced when non-preferred providers are used. This is a summary of benefit highlights only. All benefits shown indicate member responsibility.
 2 Blue FocusCareSM plans are available only in Ratings Area 1. Please see your benefit booklet for more information.
 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 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.
 6 Prescription benefit coverage starts after annual medical deductible has been met, not counting copays. Retail stores in the Preferred Pharmacy Network offer members prescriptions with a lower possible copay amount.
 7 Six prescription drug payment level tiers: Preferred Generic / Non-Preferred Generic / Preferred Brand / Non-Preferred Brand / Preferred Specialty / Non-Preferred Specialty
 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.
*** This plan is not available on the Health Insurance Marketplace in Illinois.**