BlueCross BlueShield of Illinois

# State of Illinois
## Employee and Retiree*

## Blue Choice Options℠ - Open Access Plan (OAP) Tiers I, II & III

**Tier I:** Receive the highest level of benefits by using a participating provider in the Blue Choice Options - OAP Tier I network
**Tier II:** Receive care from a provider within the PPO network
**Tier III:** Receive care from an out-of-network provider

The benefits described below represent coverage with each plan.

| Benefit | Tier I | Tier II | Tier III |
|---|---|---|---|
| Plan year out-of-pocket maximum | $3,000 per individual (includes eligible charges from Tier I and Tier II combined)<br>$6,000 per family (includes eligible charges from Tier I and Tier II combined) | | Not applicable |
| Plan year deductible (must be satisfied for all services) | $0 | $300 per enrollee** | $400 per enrollee** |
| **Hospital Services (percentages listed represent how much is covered by the plan)** | | | |
| Emergency room services | $275 copayment per visit | $275 copayment per visit | $275 copayment per visit |
| Inpatient hospitalization | $425 copayment per admission | 90% of network charges after $475 copayment per admission** | 60% of allowable charges after $575 copayment per admission** |
| Inpatient alcohol and substance abuse | $425 copayment per admission | 90% of network charges after $475 copayment per admission** | 60% of allowable charges after $575 copayment per admission** |
| Inpatient psychiatric admission | $425 copayment per admission | 90% of network charges after $475 copayment per admission** | 60% of allowable charges after $575 copayment per admission** |
| Outpatient surgery | $300 copayment per visit | 90% of network charges after $300 copayment** | 60% of allowable charges after $300 copayment** |
| Skilled nursing facility | 100% covered | 90% of network charges** | Not covered |
| Diagnostic lab and X-ray | 100% covered | 90% of network charges** | 60% of allowable charges** |
| Complex imaging (CT/Pet Scans/MRIs) | $30 copayment | 90% of network charges** | 60% of allowable charges** |
| **Transplant Services** | | | |
| Organ and tissue transplants | Tier I: 100% covered. Tier II: 90% of network charges.** Tier III: Not covered. To assure coverage, the transplant candidate must contact the plan provider prior to beginning evaluation services. | | |
| **Professional and Other Services** | | | |
| Preventive care/well-baby/ immunizations | 100% covered | 100% covered | Not covered |
| Physician office visits | $30 copayment | 90% of network charges** | 60% of allowable charges** |
| Specialist office visits | $35 copayment | 90% of network charges** | 60% of allowable charges** |
| Telemedicine | $30 or $35 copayment | 90% of network charges** | 60% of allowable charges** |
| Outpatient psychiatric and substance abuse | $30 or $35 copayment | 90% of network charges** | 60% of allowable charges** |
| Durable medical equipment | 80% of network charges | 80% of network charges** | 60% of allowable charges** |
| Home health care | $35 copayment | 90% of network charges** | Not covered |
| Prescription drugs | Administered through the state self-insured prescription benefits manager | Administered through the state self-insured prescription benefits manager | Administered through the state self-insured prescription benefits manager |

* Effective 7/1/23 to 6/30/24
** A plan year deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

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