

State of Illinois

Employee and Retiree*

For more information, call
Customer Service at **855-810-6537**,
Monday - Friday, 8 a.m. to 6 p.m. CT.

Blue Choice OptionsSM – Open Access Plan 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 (BlueCard® PPO claims are treated as Tier 1)

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) \$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 use	\$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.		
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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	\$40 copayment	90% of network charges**	60% of allowable charges**
Telemedicine	\$30 or \$35 copayment	Not covered	Not covered
Outpatient psychiatric and substance use	\$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	\$40 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 7/1/24 to 6/30/25

** 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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