BlueCross BlueShield of Illinois

State of Illinois

Local Government Health Plan*

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

Blue Choice Options℠ – 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	$7,250 per individual (includes eligible charges from Tier I and Tier II combined) $13,750 per family (includes eligible charges from Tier I and Tier II combined)		Not applicable
Plan year deductible (must be satisfied for all services)	$0	$400 per enrollee**	$600 per enrollee**
Hospital Services (percentages listed represent how much is covered by the plan)			
Emergency room services	$300 copayment per visit	$300 copayment per visit	$300 copayment per visit
Inpatient hospitalization	$350 copayment per admission	80% of network charges after $400 copayment per admission**	50% of allowable charges after $500 copayment per admission**
Inpatient alcohol and substance use	$350 copayment per admission	80% of network charges after $400 copayment per admission**	50% of allowable charges after $500 copayment per admission**
Inpatient psychiatric admission	$350 copayment per admission	80% of network charges after $400 copayment per admission**	50% of allowable charges after $500 copayment per admission**
Outpatient surgery	$300 copayment per visit	80% of network charges after $300 copayment**	50% of allowable charges after $300 copayment**
Skilled nursing facility	85% covered	85% of network charges**	Not covered
Diagnostic lab and X-ray	100% covered	80% of network charges**	50% 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	$40 copayment	80% of network charges**	50% of allowable charges**
Specialist office visits	$45 copayment	80% of network charges**	50% of allowable charges**
Telemedicine	$40 or $45 copayment	Not covered	Not covered
Outpatient psychiatric and substance use	$40 or $45 copayment	80% of network charges**	50% of allowable charges**
Durable medical equipment	70% of network charges	60% of network charges**	50% of allowable charges**
Home health care	$45 copayment	75% 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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