Champaign County BCBS Medical Plan - 9/1/2025

	BCBSIL BlueChoice Select Member Responsibility		In-Network Benefits AFTER HRA Payments
Member Benefits	**In-Network**	**Out-of-Network**	
Calendar Year Plan Deductible	Single: $5,000 Family: $10,000	Single: $10,000 Family: $20,000	Single: $2,000 Family: $4,000
Calendar Year Out-of-Pocket Maximum	Single: $5,000 Family: $10,000 *Includes deductibles, coinsurance and copayments*	Single: $10,000 Family: $20,000 *Includes deductibles, coinsurance and copayments*	Single: $2,000 Family: $4,000 *Includes deductibles, coinsurance and some copayments /* *When your Out-of-Pocket expense limit has reached $2,000/individual or $4,000/family, the HRA Benefit will begin to pay . Provided all services are received in-network, you will not be responsible for any further covered service.*
Preventive Services *Immunizations, adult and child annual physicals, mammograms, PAPs, cancer screenings and additional USPSTF items*	$0 copayment *deductible does not apply*	Deductible first 20% coinsurance	$0 copayment *deductible does not apply*
Primary Care Visit	$25 copayment *deductible does not apply*	Deductible first 20% coinsurance	$25 copayment *deductible does not apply*
Specialist Office Visit	$50 copayment *deductible does not apply*	Deductible first 20% coinsurance	$50 copayment *deductible does not apply*
Outpatient and Diagnostic Testing *X-ray, lab, MRI, CT scan etc*	Deductible first 0% coinsurance	Deductible first 20% coinsurance	Deductible first 0% coinsurance
Facility Fee	Deductible first 0% coinsurance	Deductible first 20% coinsurance	Deductible first 0% coinsurance
Outpatient Surgery/Procedures	Deductible first 0% coinsurance	Deductible first 20% coinsurance	Deductible first 0% coinsurance
Inpatient Hospitalization	Deductible first 0% coinsurance	Deductible first 20% coinsurance	Deductible first 0% coinsurance
Urgent Care Visit	Deductible first 0% coinsurance	Deductible first 20% coinsurance	Deductible first 0% coinsurance
Emergency Department Visits	$200 copayment *deductible does not apply*	$200 copayment *deductible does not apply*	$200 copayment *deductible does not apply*
Emergency Ambulance	$100 copayment *deductible does not apply*	$100 copayment *deductible does not apply*	$100 copayment *deductible does not apply*
Mental Health, Behavioral Health or Substance Abuse Services	Same as any other charge	Same as any other charge	Same as any other charge
Outpatient Prescriptions Retails	*deductible does not apply*	*deductible does not apply*	*deductible does not apply*
Generic	$7 copayment	$7 copayment + 25%	$7 copayment
Preferred Brand	$25 copayment	$25 copayment + 25%	$25 copayment
Non-Preferred Brand	$50 copayment	$50 copayment + 25%	$50 copayment
Specialty	$100 copayment	$100 copayment + 25%	$100 copayment
	CVS / Target / Schnucks NOT covered		
Outpatient Prescriptions Mail-Order	2 X co-pay for 90 day supply	Not Covered	2 X co-pay for 90 day supply

This is a brief summary of BCBS benefits for illustrative purposes only. It is not a contract and offers no contractual obligation on behalf of GBS. Please refer to the BCBS policy for detailed information regarding coverage