BlueCross BlueShield of Illinois

Chicagoland (PPO) 2026

		Blue Cross Medicare Advantage Choice Plus (PPO)SM H8634-003		Blue Cross Medicare Advantage Choice Premier (PPO)SM H8634-004		Blue Cross Medicare Advantage Classic (PPO)SM H8634-008	
Plan Premium		**$90**		**$155**		**$0**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$0		$0		$0	
Primary Care Provider Visits		$0 Copay	50% Coinsurance	$0 Copay	50% Coinsurance	$0 Copay	50% Coinsurance
Specialist Visits		$52 Copay	50% Coinsurance	$45 Copay	50% Coinsurance	$17 Copay	50% Coinsurance
Maximum Out-of-Pocket		$5,100	$10,100	$4,850	$10,100	$5,500	$10,100
Inpatient Hospital Copay		$350/day for days 1–8	50% Coinsurance	$350/day for days 1–7	50% Coinsurance	$380/day for days 1–7	50% Coinsurance
Outpatient Hospital Copay		$360 maximum	50% Coinsurance	$350 maximum	50% Coinsurance	$380	50% Coinsurance
Labs		$5	50% Coinsurance	$5	50% Coinsurance	$5	50% Coinsurance
X-ray/CT Scan/MRI		$0–$300	50% Coinsurance	$0–$200	50% Coinsurance	$0–$300	50% Coinsurance
Ambulance/Air Ambulance		$250/20%		$225/20%		$250/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	$750 annually		$750 annually		$1,000 annually	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	$40 allowance	$0 Copay; 1 exam/year	$40 allowance	$0 Copay; 1 exam/year	$40 allowance
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay		$699 or $999 Copay		$699 or $999 Copay	
Pharmacy	Preferred Retail Pharmacy Copays	$0/$1/17%/37%/27%		$0/$1/18%/42%/29%		$0/$1/17%/36%/25%	
	Prescription Drug Deductible	$450		$300		$615	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		Not Covered		Not Covered	
Flexible Spend Card[2]		Not Included		Not Included		Not Included	
Optional Supplemental Benefits Plan[3]		Silver		Not Applicable		Silver	
Plan Premium		$36.40				$33.20	
Dental	Annual Allowance	$1,000				$1,000	
	Routine Preventive	Not Included				Not Included	
	Basic Restorative	Not Included				Not Included	
	Major Restorative	20% Coinsurance	50% Coinsurance			20% Coinsurance	50% Coinsurance
Vision	Glasses/Contacts Allowance	Not Included				Not Included	

See reverse for additional benefit details

BlueCross BlueShield of Illinois

Chicagoland (PPO) cont.

2026

		Blue Cross Medicare Advantage Dental Premier (PPO)℠ H8634-021		Blue Cross Medicare Advantage Health Choice (PPO)℠ H8634-018	
Plan Premium		**$0**		**$0**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$0		$0	
Primary Care Provider Visits		$0 Copay	50% Coinsurance	$0 Copay	50% Coinsurance
Specialist Visits		$25 Copay	50% Coinsurance	$45 Copay	50% Coinsurance
Maximum Out-of-Pocket		$7,500	$13,900	$9,000	$13,900
Inpatient Hospital Copay		$370/day for days 1–6	50% Coinsurance	$365/day for days 1–7	50% Coinsurance
Outpatient Hospital Copay		$400 maximum	50% Coinsurance	$400 maximum	50% Coinsurance
Labs		$5	50% Coinsurance	$5	50% Coinsurance
X-ray/CT Scan/MRI		$0–$300	50% Coinsurance	$0–$100	50% Coinsurance
Ambulance/Air Ambulance		$225/20%		$225/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	$3,000 annually		$750 annually	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	$40 allowance	$0 Copay; 1 exam/year	$40 allowance
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay		$699 or $999 Copay	
Pharmacy	Preferred Retail Pharmacy Copays	$0/$1/17%/32%/25%		$0/$1/17%/36%/25%	
	Prescription Drug Deductible	$615		$615	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		$40 every 3 months	
Flexible Spend Card[2]		Not Included		$500/annually for dental, vision, and hearing	
Optional Supplemental Benefits Plan[3]		Not Applicable		Not Applicable	
Plan Premium					
Dental	Annual Allowance				
	Routine Preventive				
	Basic Restorative				
	Major Restorative				
Vision	Glasses/Contacts Allowance				

See reverse for additional benefit details

BlueCross BlueShield of Illinois

Chicagoland (PPO) cont.

2026

		Blue Cross Medicare Advantage Essential (PPO)℠ H8634-012		Blue Cross Medicare Advantage Protect (PPO)℠ H8634-019	
Plan Premium		**$0**		**$0**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$0		$40	
Primary Care Provider Visits		$5 Copay	50% Coinsurance	$0 Copay	50% Coinsurance
Specialist Visits		$67 Copay	50% Coinsurance	$60 Copay	50% Coinsurance
Maximum Out-of-Pocket		$6,700	$10,100	$6,750	$10,100
Inpatient Hospital Copay		$350/day for days 1–6	50% Coinsurance	$370/day for days 1–6	50% Coinsurance
Outpatient Hospital Copay		$400 maximum	50% Coinsurance	$400 maximum	50% Coinsurance
Labs		$5	50% Coinsurance	$5	50% Coinsurance
X-ray/CT Scan/MRI		$0–$300	50% Coinsurance	$0–$300	50% Coinsurance
Ambulance/Air Ambulance		$225/20%		$225/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	$750 annually		$1,000 annually	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	$40 allowance	$0 Copay; 1 exam/year	$40 allowance
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay		$699 or $999 Copay	
Pharmacy	Preferred Retail Pharmacy Copays	$0/$1/17%/39%/27%		Not Covered	
	Prescription Drug Deductible	$450		Not Covered	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		Not Covered	
Flexible Spend Card[2]		Not Included		Not Included	
Optional Supplemental Benefits Plan[3]		Silver		Silver	
Plan Premium		$46.30		$46.10	
Dental	Annual Allowance	$1,000		$1,000	
	Routine Preventive	Not Included		Not Included	
	Basic Restorative	Not Included		Not Included	
	Major Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
Vision	Glasses/Contacts Allowance	Not Included		Not Included	

See reverse for additional benefit details

Blue Cross Medicare Advantage℠ plans	Offered in the following counties
Choice Plus (PPO) - H8634-003	Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will
Choice Premier (PPO) - H8634-004	Cook, DeKalb, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will
Classic (PPO) - H8634-008	Kankakee, McHenry
Dental Premier (PPO) - H8634-021 **Health Choice (PPO) - H8634-018** **Protect (PPO) - H8634-019**	Kankakee, La Salle, McHenry
Essential (PPO) - H8634-012	Kankakee, La Salle

Plans vary by county. Refer to the Summary of Benefits for plan availability and more information about what we cover and what you pay. Learn more at **www.getblueil.com/mapd/sb**

[1] **Over-the-Counter Items.** You can purchase approved over-the-counter (OTC) items at no cost based on your plan limit. This includes OTC items like pain relievers and allergy medicine to help with your basic health and medical needs.

[2] **Flexible Spend Card.** Pre-loaded flexible spend card with an annual limit of $1,000 to help reduce out-of-pocket expenses for dental, vision and hearing services.

[3] **Optional Supplemental Benefits Plan.** For an additional monthly premium, you can add more coverage to your plan. Adding supplemental benefits to your current plan is optional and provides you with additional dental and vision coverage.

Preferred Pharmacy Network. Save money when you fill your covered prescriptions at a convenient preferred pharmacy, including Walgreens, Jewel-Osco, Walmart, Kroger, Mariano's and select independent pharmacies.

Prescription Drug Tiers:
Tier 1 – Preferred Generic
Tier 2 – Generic
Tier 3 – Preferred Brand
Tier 4 – Non-Preferred
Tier 5 – Specialty

Additional Benefits:

Rewards Program. The Rewards Program gives you a healthy and easy way to earn up to $100 in gift cards from major retailers for completing Healthy Actions throughout the year. Visiting your doctor at least once a year can help you catch small health problems before they become big ones. You can earn up to $50 in gift cards just for completing your annual wellness visit! Earn rewards with these Healthy Actions:

-Mammogram
-Fall risk assessment
-Retinal eye exam
-Annual flu vaccine
-Annual wellness visit
-Colorectal cancer screening
-Bone density screening
-Diabetic kidney and blood sugar testing

Telehealth Benefits. Conveniently access health care services remotely via phone, computer or tablet with $0 copays.

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