### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://marketplace.illinicare.com/ or by calling 855-745-5507, TTY/TDD 866-565-8576

| ***************************************                         | *  | Most this Matters  |  |  |
|---|--|--|--|--|
| Important Questions   | Answers  | Why this Matters:  |  |  |
| What is the overall deductible?                                 | <b>\$1,000</b> individual / <b>\$2,000</b> family. Does not apply to preventive care and prescription drugs. | The covered services you use theck your noucy plan or plan document to see when the <b>deall</b>                 |  |  |
| Are there other   | Yes, <b>\$500</b> individual / <b>\$1,000</b>  | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this         |  |  |
| deductibles for specific  | family for prescription drug   | plan begins to pay for these services.   |  |  |
| services?   | expenses.  | pian begins to pay for these services.   |  |  |
| Is there an out-of-   | Yes, for in-network providers  | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year)             |  |  |
| pocket-limit on my  | <b>\$6,350</b> individual/ <b>\$12,700</b> family.   | for your share of the cost of covered services. This limit helps you plan for health care expenses.              |  |  |
| expenses?   | No, for out-of-network providers.  | for your share of the cost of covered services. This infint helps you plan for health care expenses.             |  |  |
| What is not included in   | Premiums, balance-billed charges,  |  |  |  |
| the <u>out-of-pocket limit</u> ?                                | and out-of-network services this   | Even though you pay these expenses, they don't count toward the out-of-pocket limit.                             |  |  |
| the out or pocket mint.   | plan doesn't cover.  |  |  |  |
| Is there an overall annual                                      |  | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered          |  |  |
| limit on what the plan  | No   | services, such as office visits.   |  |  |
| pays?   |  |  |  |  |
|   | Yes. See http://   | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of         |  |  |
| Does this plan use a  | marketplace.illinicare.com/  | the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-                   |  |  |
| network of providers?   | findadocor call  | network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating    |  |  |
| network of providers.   | <b>1-855-745-5507</b> for a list of  | for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different |  |  |
|   | participating providers.   | kinds of <b>providers</b> .  |  |  |
| <b>Do I need a referral to</b> No, you don't need a referral to |  | You can see the <b>specialist</b> you choose without permission from this plan.                                  |  |  |
| see a specialist?   | see a specialist.  | · · ·  |  |  |
| Are there services this   | Yes  | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan                       |  |  |
| plan doesn't cover?   |  | document for additional information about excluded services.   |  |  |

Questions: Call 855-745-5507, TTY/TDD 866-565-8576 or visit us at http://marketplace.illinicare.com/.

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### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u> you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>).
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

| Common Medical<br>Event                             | Services You May Need                            | Your Cost If<br>You Use an In-<br>network Provider |             | Limitations & Exceptions |
|---|--|--|-------------|--------------------------|
|   | Primary care visit to treat an injury or illness | 20% Coinsurance after deductible                   | Not covered | None                     |
| If you visit a health care <u>provider's</u> office | Specialist visit                                 | 20% Coinsurance after deductible                   | Not covered | None                     |
| or clinic   | Other practitioner office visit                  | 20% Coinsurance after deductible                   | Not covered | None                     |
|   | Preventive care/screening/immunization           | No charge  | Not covered | None                     |
| If you have a took                                  | Diagnostic test (x-ray, blood work)              | 20% Coinsurance after deductible                   | Not covered | Prior approval required  |
| If you have a test                                  | Imaging (CT/PET scans, MRIs)                     | 20% Coinsurance after deductible                   | Not covered | Prior approval required. |

**Coverage Period:** 

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HMO

| Common Medical<br>Event   | Services You May Need                          | Your Cost If<br>You Use an In-<br>network Provider | Your Cost If You<br>Use an Out-of-<br>network Provider | Limitations & Exceptions  |
|---|--|--|--|---|
| If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at http://marketplace.illini care.com/formulary. | Generic drugs                                  | \$10 Copay/30 day supply.                          | Not covered  | None  |
|   | Preferred brand drugs                          | \$25 Copay after deductible/30 day supply.         | Not covered  |   |
|   | Non-preferred brand drugs                      | \$75 Copay after deductible/30 day supply.         | Not covered  | \$500 individual / \$1,000 family Rx<br>deductible for preferred brand drugs, non-<br>preferred brand drugs and specialty drugs |
|   | Specialty drugs                                | 30% Coinsurance after deductible/30 day supply.    | Not covered  |   |
| If you have outpatient  | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after deductible                   | Not covered  | Prior approval required   |
| surgery   | Physician/surgeon fees                         | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Emergency room services                        | \$250 Copay after deductible /visit                | \$250 Copay after deductible /visit                    | None  |
| If you need immediate medical attention   | Emergency medical transportation               | 20% Coinsurance after deductible                   | 20% Coinsurance after deductible                       | None  |
|   | Urgent care                                    | 20% Coinsurance after deductible                   | Not covered  | None  |
| If you have a hospital  | Facility fee (e.g., hospital room)             | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
| stay  | Physician/surgeon fee                          | 20% Coinsurance<br>after deductible                | Not covered  | Prior approval required.  |

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Coverage Period:

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

| Common Medical<br>Event   | Services You May Need                        | Your Cost If<br>You Use an In-<br>network Provider | Your Cost If You<br>Use an Out-of-<br>network Provider | Limitations & Exceptions  |
|---|--|--|--|---|
| If you have mental<br>health, behavioral<br>health, or substance<br>abuse needs | Mental/Behavioral health outpatient services | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Mental/Behavioral health inpatient services  | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Substance use disorder outpatient services   | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Substance use disorder inpatient services    | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
| If you are pregnant   | Prenatal and postnatal care                  | 20% Coinsurance after deductible                   | Not covered  | None  |
|   | Delivery and all inpatient services          | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
| If you need help<br>recovering or have<br>other special health<br>needs         | Home health care                             | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Rehabilitation services                      | 20% Coinsurance after deductible                   | Not covered  | Prior approval required after limits have<br>been met. 60 Visit(s) per Year |
|   | Habilitation services                        | 20% Coinsurance after deductible                   | Not covered  | Prior approval required.  |
|   | Skilled nursing care                         | 20% Coinsurance after deductible                   | Not covered  | None  |
|   | Durable medical equipment                    | 20% Coinsurance after deductible                   | Not covered  | Prior approval required   |
|   | Hospice service                              | 20% Coinsurance after deductible                   | Not covered  | Prior approval required   |

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### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO

| Common<br>Event                        | Medical         | Services You May Need | Your Cost If<br>You Use an In-<br>network Provider |                    | Limitations & Exceptions |
|--|-----------------|-----------------------|--|--------------------|--------------------------|
| If your abil                           | ld noods        | Eye exam              | \$20 Copay/visit                                   | Not covered        | 1 Visit(s) per Year      |
| If your child needs dental or eye care | Glasses         | \$20 Copay/pair       | Not covered  | 1 Item(s) per Year |                          |
|  | Dental check-up | Not covered           | Not covered  | None               |                          |

### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO

#### **Excluded Services & Other Covered Services**

### Services Your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Weight loss programs

• Long-term care

Non-emergency care when traveling outside the U.S.

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- · Bariatric surgery
- Dental care (Adult comprehensive dental benefits, class 2 are subject to a six month waiting period)
- Private-duty nursing (On an outpatient basis)
- Chiropractic care
- Hearing aids (Coverage for bone anchored hearing aids and cochlear implants only)
- Routine eye care (Adult)

- Cosmetic surgery
- Infertility treatment (See policy for coverage details)
- Routine foot care (For diabetes treatment)

### **Your Rights to Continue Coverage**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- · You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 855-745-5507, TTY/TDD 866-565-8576. You may also contact your state insurance department at Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515.

### **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: Illinois Department of Insurance, 320 W. Washington, 4th Floor, Springfield, IL 62767, Phone No. (217) 782-4515.

Additionally, a consumer assistance program can help you file your appeal. Contact (877) 527-9431

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### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO

### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health** coverage does meet the minimum value standard for the benefits it provides.

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 855-745-5507, TTY/TDD 866-565-8576

—— To see examples of how this plan might cover costs for a sample medical situation, see the next page. -

**Coverage Examples** 

### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO

# **About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,120
- Patient pays \$2,420

### Sample care costs:

| Hospital charges (mother)  | \$2,700 |
|----------------------------|---------|
| Routine obstetric care     | \$2,100 |
| Hospital charges (baby)    | \$900   |
| Anesthesia                 | \$900   |
| Laboratory tests           | \$500   |
| Prescriptions              | \$200   |
| Radiology                  | \$200   |
| Vaccines, other preventive | \$40    |
| Total                      | \$7,540 |
| Patient pays Deductibles   | \$1,020 |
| Copays                     | \$0     |
| Coinsurance                | \$1,250 |
| Limits or exclusions       | \$150   |
| Total                      | \$2,420 |

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,190
- Patient pays \$2,210

### Sample care costs:

| Prescriptions                  | \$2,900 |
|--------------------------------|---------|
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures   | \$700   |
| Education                      | \$300   |
| Laboratory tests               | \$100   |
| Vaccines, other preventive     | \$100   |
| Total                          | \$5,400 |

### Patient pays

| Deductibles          | \$1,500 |
|----------------------|---------|
| Copays               | \$350   |
| Coinsurance          | \$280   |
| Limits or exclusions | \$80    |
| Total                | \$2,210 |

**Coverage Examples** 

### **Coverage Period:**

Coverage for: Individual/Family | Plan Type: HMO

### **Questions and answers about the Coverage Examples:**

# What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

# What does a Coverage Example show?

For each treatment situation, the Coverage Examples helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

# Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

# Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

# Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

# Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.