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

#### 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

| Important Questions  | Answers  | Why this Matters:   |
|--|--|---|
| What is the overall<br><u>deductible</u> ?                           | <b>\$5,000</b> individual / <b>\$10,000</b> family. Does not apply to preventive care and prescription drugs.                  | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for<br>covered services you use. Check your policy plan or plan document to see when the <u>deductible</u><br>starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much<br>you pay for covered services after you meet the <u>deductible</u> .   |
| Are there other<br><u>deductibles</u> for specific<br>services?      | Yes, <b>\$750</b> individual / <b>\$1,500</b> family for prescription drug expenses.   | You must pay all of the costs for these services up to the specific <b><u>deductible</u></b> amount before this plan begins to pay for these services.  |
| Is there an <u>out-of-</u><br><u>pocket-limit</u> on my<br>expenses? | Yes, for in-network providers<br>\$6,350 individual/\$12,700 family.<br>No, for out-of-network providers.                      | The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.   |
| What is not included in the <u>out-of-pocket limit</u> ?             | Premiums, balance-billed charges,<br>and out-of-network services this<br>plan doesn't cover.                                   | Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .   |
| Is there an overall annual<br>limit on what the plan<br>pays?        | No   | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| Does this plan use a<br><u>network</u> of <u>providers</u> ?         | Yes. See http://<br>marketplace.illinicare.com/<br>findadocor call<br>1-855-745-5507 for a list of<br>participating providers. | If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?                    | No, you don't need a referral to see a specialist.   | You can see the <b><u>specialist</u></b> you choose without permission from this plan.  |
| Are there services this plan doesn't cover?                          | Yes  | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .   |

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- 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</u> <u>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</u> <u>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 **<u>deductibles</u>**, **<u>copayments</u>**, and <u>coinsurance</u> amounts.

| 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 |
|--|--|--|--|--------------------------|
|  | Primary care visit to treat an injury or illness | \$25 Copay/visit                                   | Not covered  | None                     |
| If you visit a health                      | Specialist visit                                 | \$50 Copay/visit                                   | Not covered  | None                     |
| care <u>provider's</u> office<br>or clinic | Other practitioner office visit                  | \$25 Copay/visit                                   | Not covered  | None                     |
|  | Preventive care/screening/immunization           | No charge  | Not covered  | None                     |
| If you have a test                         | Diagnostic test (x-ray, blood work)              | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required  |
| If you have a test                         | Imaging (CT/PET scans, MRIs)                     | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required. |

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

#### **Coverage Period:**

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    |  | Limitations & Exceptions  |
|---|--|---|--|---|
| If you need drugs to  | Generic drugs                                  | \$10 Copay/30 day<br>supply.                          | Not covered                            | None  |
| treat your illness or<br>condition                                      | Preferred brand drugs                          | \$60 Copay after<br>deductible/30 day<br>supply.      | Not covered                            |   |
| More information about<br>prescription drug<br>coverage is available at | Non-preferred brand drugs                      | 50% Coinsurance<br>after deductible/30<br>day supply. | Not covered                            | \$750 individual / \$1,500 family Rx<br>deductible for preferred brand drugs, non-<br>preferred brand drugs and specialty drugs |
| http://marketplace.illini<br>care.com/formulary.                        | Specialty drugs                                | 50% Coinsurance<br>after deductible/30<br>day supply. | Not covered                            |   |
| If you have outpatient  | Facility fee (e.g., ambulatory surgery center) | 30% Coinsurance<br>after deductible                   | Not covered                            | Prior approval required   |
| surgery   | Physician/surgeon fees                         | 30% Coinsurance<br>after deductible                   | Not covered                            | Prior approval required.  |
| If you need immediate   | Emergency room services                        | \$400 Copay after<br>deductible /visit                | \$400 Copay after<br>deductible /visit | None  |
| If you need immediate medical attention                                 | Emergency medical transportation               | 30% Coinsurance<br>after deductible                   | 30% Coinsurance<br>after deductible    | None  |
|   | Urgent care                                    | \$100 Copay/visit                                     | Not covered                            | None  |
| If you have a hospital<br>stay  | Facility fee (e.g., hospital room)             | 30% Coinsurance<br>after deductible                   | Not covered                            | Prior approval required.  |
|   | Physician/surgeon fee                          | 30% Coinsurance<br>after deductible                   | Not covered                            | Prior approval required.  |

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#### **Coverage Period:**

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  |
|--|---|--|--|---|
|  | Mental/Behavioral health outpatient services                | \$25 Copay/visit                                   | Not covered  | Prior approval required.  |
| If you have mental<br>health, behavioral | Mental/Behavioral health inpatient services                 | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required.  |
| health, or substance                     | Substance use disorder outpatient services                  | \$25 Copay/visit                                   | Not covered  | Prior approval required.  |
| abuse needs                              | Substance use disorder inpatient services                   | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required.  |
|  | Prenatal and postnatal care                                 | \$25 Copay/visit                                   | Not covered  | None  |
| If you are pregnant                      | Delivery and all inpatient services                         | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required.  |
|  | Home health care  | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required.  |
| If you need help<br>recovering or have   | Rehabilitation services                                     | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required after limits have<br>been met. 60 Visit(s) per Year |
|  | Habilitation services                                       | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required   |
| other special health<br>needs            | health     30% Coinsurance after deductible     Not covered | None   |  |   |
|  | Durable medical equipment                                   | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required   |
|  | Hospice service   | 30% Coinsurance<br>after deductible                | Not covered  | Prior approval required   |
| If your shild needs                      | Eye exam  | \$20 Copay/Visit                                   | Not covered  | 1 Visit(s) per Year   |
| If your child needs                      | Glasses   | \$20 Copay/Pair                                    | Not covered  | 1 Item(s) per Year  |
| dental or eye care                       | Dental check-up   | Not covered  | Not covered  | None  |

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• Infertility treatment (See policy for coverage

• Routine foot care (For diabetes treatment)

• Cosmetic surgery

details)

#### **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   | • Long-term care | • Non-emergency care when traveling outside the |
| Weight loss programs  |                  | 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.)

• Hearing aids (Coverage for bone anchored

hearing aids and cochlear implants only)

• Chiropractic care

• Routine eye care (Adult)

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)

#### 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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#### **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** <u>does provide</u> 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 <u>does meet</u> 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.  $\cdot$ 

Questions: Call 855-745-5507, TTY/TDD 866-565-8576 or visit us at http://marketplace.illinicare.com/. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 855-745-5507, TTY/TDD 866-565-8576 to request a copy. 68432IL0060008-00

#### **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 \$1,690
- Patient pays \$5,850

#### Sample care costs:

| Total                      | \$7,540 |
|----------------------------|---------|
| Vaccines, other preventive | \$40    |
| Radiology                  | \$200   |
| Prescriptions              | \$200   |
| Laboratory tests           | \$500   |
| Anesthesia                 | \$900   |
| Hospital charges (baby)    | \$900   |
| Routine obstetric care     | \$2,100 |
| Hospital charges (mother)  | \$2,700 |

#### Patient pays

| Deductibles          | \$5,020 |
|----------------------|---------|
| Copays               | \$0     |
| Coinsurance          | \$680   |
| Limits or exclusions | \$150   |
| Total                | \$5,850 |

Managing type 2 diabetes (routine maintenance of a

well-controlled condition)

- Amount owed to providers: \$5,400
- **Plan pays** \$1,840
- Patient pays \$3,560

#### 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          | \$3,170 |
|----------------------|---------|
| Copays               | \$310   |
| Coinsurance          | \$0     |
| Limits or exclusions | \$80    |
| Total                | \$3,560 |

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**Coverage Examples** 

#### **Coverage Period:**

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## **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 **providers**. If the patient had received care from out-of-network **providers**, 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?

**X**<u>No</u>. 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.

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