

Molina Marketplace Benefits At A Glance - Illinois

Affordable, quality health coverage for all. Learn more at [ChooseMolina.com](https://www.ChooseMolina.com)



Call today! (833) 543-1893 (TTY: 711)

Silver 1				Silver 1 with Rx Copay and Adult Vision Services			
Cost Sharing Reduction Plans (CSR)				Cost Sharing Reduction Plans (CSR)			
Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 1 100 with Rx Copay and Adult Vision Services	Silver 1 150 with Rx Copay and Adult Vision Services	Silver 1 200 with Rx Copay and Adult Vision Services	Silver 1 250 with Rx Copay and Adult Vision Services

VALUE BASICS

Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free	Free	Free	Free	Free
Annual Wellness Visit - Adults	Free	Free	Free	Free	Free	Free	Free	Free
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free	Free	Free	Free	Free
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free	Free	Free	Free	Free
Preventive Prescription Drugs	Free	Free	Free	Free	Free	Free	Free	Free
24-Hour Nurse Advice Line	Free	Free	Free	Free	Free	Free	Free	Free
Plan Options with Adult Vision Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

BENEFITS AND COST SHARE HIGHLIGHTS

Deductible (Ind/Fam)	\$0 / \$0	\$850 / \$1,700	\$3,500 / \$7,000	\$5,750 / \$11,500	\$0 / \$0	\$850 / \$1,700	\$3,500 / \$7,000	\$5,750 / \$11,500
Drug Deductible (Ind/Fam)	\$0 / \$0	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	\$0 / \$0	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	\$2,700 / \$5,400	\$2,825 / \$5,650	\$6,775 / \$13,550	\$7,940 / \$15,880	\$2,700 / \$5,400	\$2,825 / \$5,650	\$6,675 / \$13,350	\$7,940 / \$15,880
Emergency Room Facility	15%	30% after ded	40% after ded	40% after ded	15%	30% after ded	40% after ded	40% after ded
Urgent Care Services	\$5	\$25	\$55	\$55	\$5	\$25	\$55	\$55

** Denotes no charge for the first 4 non-preventive office visits for any combination of the indicated visit types. [§]Mail-order is available for non-specialty drugs marked "MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.

SERVICES WITHOUT ANY DEDUCTIBLE

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	Silver 1				Silver 1 with Rx Copay and Adult Vision Services			
	Cost Sharing Reduction Plans (CSR)				Cost Sharing Reduction Plans (CSR)			
	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 1 100 with Rx Copay and Adult Vision Services	Silver 1 150 with Rx Copay and Adult Vision Services	Silver 1 200 with Rx Copay and Adult Vision Services	Silver 1 250 with Rx Copay and Adult Vision Services
INPATIENT SERVICES								
Inpatient Facility Fee <i>*Professional Fees May Apply</i>	15%	30% after ded	40% after ded	40% after ded	15%	30% after ded	40% after ded	40% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES								
Primary Care	\$0	\$8	\$30	\$35	\$0	\$8	\$30	\$35
Specialty Care	\$10	\$30	\$60	\$60	\$10	\$30	\$60	\$60
Rehabilitative and Habilitative Services	\$10	\$30	\$30	\$35	\$10	\$30	\$10	\$35
Mental / Behavioral Health Services / Substance Use Disorder Services	\$0	\$8	\$30	\$35	\$0	\$8	\$30	\$35
OUTPATIENT HOSPITAL FACILITY SERVICES								
Outpatient Facility Fee	15%	30% after ded	40% after ded	40% after ded	15%	30% after ded	40% after ded	40% after ded
Outpatient Professional Fee	15%	30% after ded	40% after ded	40% after ded	15%	30% after ded	40% after ded	40% after ded
Advanced Imaging and Specialized Scanning Services	15%	30% after ded	40% after ded	40% after ded	15%	30% after ded	40% after ded	40% after ded
Routine X-Ray and Diagnostic Services	\$30	\$75	\$95	\$95	\$30	\$75	\$95	\$95
Laboratory Tests	\$10	\$30	\$60	\$75	\$10	\$30	\$60	\$75

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	Silver 1				Silver 1 with Rx Copay and Adult Vision Services			
	Cost Sharing Reduction Plans (CSR)			Silver 1 250	Cost Sharing Reduction Plans (CSR)			Silver 1 250 with Rx Copay and Adult Vision Services
	Silver 1 100	Silver 1 150	Silver 1 200		Silver 1 100 with Rx Copay and Adult Vision Services	Silver 1 150 with Rx Copay and Adult Vision Services	Silver 1 200 with Rx Copay and Adult Vision Services	
PRESCRIPTION DRUGS[§]								
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	\$0	\$5	\$15	\$20	\$0	\$15	\$40	\$40
Preferred Brand Drugs	\$30	\$65	\$75 after ded	\$75 after ded	\$30	\$45	\$120	\$120
Non-Preferred Drugs	15%	30% after ded	40% after ded	40% after ded	\$90	\$135	\$360	\$360
Specialty Drugs	15%	30% after ded	40% after ded	40% after ded	\$270	\$405	\$1,080	\$1,080

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	Silver 8				Silver 12 with First 4 Primary Care Visits Free				Gold 1	Gold 8 with Rx Copay
	Cost Sharing Reduction Plans (CSR)				Cost Sharing Reduction Plans (CSR)					
	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12 250		

VALUE BASICS

Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Annual Wellness Visit - Adults	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Preventive Prescription Drugs	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
24-Hour Nurse Advice Line	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Plan Options with Adult Vision Services	No	No	No	No	No	No	No	No	Yes	No

BENEFITS AND COST SHARE HIGHLIGHTS

Deductible (Ind/Fam)	\$0 / \$0	\$500 / \$1,000	\$3,000 / \$6,000	\$5,000 / \$10,000	\$150 / \$300	\$1,425 / \$2,850	\$6,500 / \$13,000	\$7,000 / \$14,000	\$1,640 / \$3,280	\$1,500 / \$3,000
Drug Deductible (Ind/Fam)	\$0 / \$0	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	\$2,000 / \$4,000	\$3,000 / \$6,000	\$6,400 / \$12,800	\$8,000 / \$16,000	\$3,050 / \$6,100	\$3,050 / \$6,100	\$7,350 / \$14,700	\$9,200 / \$18,400	\$8,100 / \$16,200	\$7,800 / \$15,600
Emergency Room Facility	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Urgent Care Services	\$5	\$30	\$60	\$60	\$3	\$13	\$55	\$60	\$20	\$45

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	Silver 8				Silver 12 with First 4 Primary Care Visits Free					
	Cost Sharing Reduction Plans (CSR)				Cost Sharing Reduction Plans (CSR)					
	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12 250	Gold 1	Gold 8 with Rx Copay

INPATIENT SERVICES

Inpatient Facility Fee <i>*Professional Fees May Apply</i>	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
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OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES

Primary Care	\$0	\$20	\$40	\$40	\$2**	\$10**	\$35**	\$40**	\$20	\$30
Specialty Care	\$10	\$40	\$80	\$80	\$4	\$15	\$60	\$62.50	\$50	\$60
Rehabilitative and Habilitative Services	\$0	\$20	\$40	\$40	10% after ded	20% after ded	20% after ded	20% after ded	\$20	\$30
Mental / Behavioral Health Services / Substance Use Disorder Services	\$0	\$20	\$40	\$40	\$2**	\$10**	\$35**	\$40**	\$20	\$30

OUTPATIENT HOSPITAL FACILITY SERVICES

Outpatient Facility Fee	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Outpatient Professional Fee	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Advanced Imaging and Specialized Scanning Services	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Routine X-Ray and Diagnostic Services	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Labratory Tests	25%	30% after ded	40% after ded	40% after ded	10% after ded	20% after ded	20% after ded	20% after ded	\$15	25% after ded

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PRESCRIPTION DRUGS §										
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	\$0	\$10	\$20	\$20	\$2	\$5	\$5	\$5	\$15	\$15
Preferred Brand Drugs	\$15	\$20	\$40	\$40	\$20	\$50	\$100	\$100	\$50 after ded	\$30
Non-Preferred Drugs	\$50	\$60 after ded	\$80 after ded	\$80 after ded	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded	\$60
Specialty Drugs	\$150	\$250 after ded	\$350 after ded	\$350 after ded	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded	\$250

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