

2024 Molina Marketplace Benefits At A Glance - Illinois

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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	Silver 1 150	Silver 1 200	Silver 1 250
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 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	\$700 / \$1,400	\$3,500 / \$7,000	\$5,000 / \$10,000	\$0 / \$0	\$700 / \$1,400	\$3,500 / \$7,000	\$5,000 / \$10,000
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)	\$1,650 / \$3,300	\$2,750 / \$5,500	\$6,775 / \$13,550	\$7,850 / \$15,700	\$1,650 / \$3,300	\$2,755 / \$5,150	\$6,700 / \$13,400	\$7,850 / \$15,700
Emergency Room Facility	20%	25% after ded	35% after ded	35% after ded	20%	25% after ded	35% after ded	35% after ded
Urgent Care Services	\$5	\$20	\$45	\$45	\$5	\$20	\$45	\$45
Inpatient Services								
Inpatient Facility Fee *Professional Fees May Apply	20%	25% after ded	35% after ded	35% after ded	20%	25% after ded	35% after ded	35% after ded

Services Without Any Deductible

Note: ** 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 two-and-a-half times (2.5x) the 30-day retail cost-sharing amount.

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	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250
Outpatient Professional Office Visits Services								
Primary Care	\$0	\$9	\$30	\$30	\$0	\$9	\$30	\$30
Specialty Care	\$10	\$30	\$60	\$60	\$10	\$30	\$60	\$60
Rehabilitative and Habilitative Services	\$10	\$30	\$30	\$30	\$5	\$9	\$30	\$30
Mental / Behavioral Health Services / Substance Abuse Services	\$0	\$9	\$30	\$30	\$0	\$9	\$30	\$30
Outpatient Hospital Facility Services								
Outpatient Facility Fee	20%	25% after ded	35% after ded	35% after ded	20%	25% after ded	35% after ded	35% after ded
Outpatient Professional Fee	20%	25% after ded	35% after ded	35% after ded	20%	25% after ded	35% after ded	35% after ded
Advanced Imaging and Specialized Scanning Services	20%	25% after ded	35% after ded	35% after ded	20%	25% after ded	35% after ded	35% after ded
Routine X-Ray and Diagnostic Services	\$30	\$75	\$95	\$95	\$30	\$75	\$95	\$95
Laboratory Tests	\$10	\$30	\$60	\$60	\$10	\$30	\$60	\$60
Prescription Drugs [§]								
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	\$0	\$6	\$20	\$29	\$0	\$15	\$40	\$40
Preferred Brand Drugs	\$30	\$65	\$65 after ded	\$65 after ded	\$30	\$45	\$120	\$120
Non-Preferred Drugs	20%	25% after ded	35% after ded	35% after ded	\$90	\$135	\$360	\$360
Specialty Drugs	20%	25% after ded	35% after ded	35% after ded	\$270	\$405	\$1,080	\$1,080

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	Silver 8				Silver 12 with First 4 Free PCP or MH Visits				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 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	\$700 / \$1,400	\$5,700 / \$11,400	\$5,900 / \$11,800	\$100 / \$200	\$1,300 / \$2,600	\$6,500 / \$13,000	\$7,000 / \$14,000	\$1,550 / \$3,100	\$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)	\$1,800 / \$3,600	\$3,000 / \$6,000	\$7,200 / \$14,400	\$9,100 / \$18,200	\$3,150 / \$6,300	\$3,150 / \$6,300	\$7,550 / \$15,100	\$9,450 / \$18,900	\$8,100 / \$16,200	\$8,700 / \$17,400
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
Inpatient Services										
Inpatient Facility Fee *Professional Fees May Apply	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

Services Without Any Deductible

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	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12 250		
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	\$70	\$75	\$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 Abuse 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
Laboratory 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
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	\$10	\$10	\$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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