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# UniCare Illinois
# Premier Flex Plus 1000-80 Plan
# Groups 2-99

This matrix is intended to help you compare the plan benefits and reflects UniCare's share of costs for covered expenses after you have met any applicable deductibles, unless noted otherwise. When you use UniCare independently contracted in-network (participating) providers, your costs are based on a specially negotiated fee for UniCare members that may save you money. When you use out-of-network (nonparticipating) providers, your costs are based on covered expenses and often result in higher costs to you.

This is only a brief description of some plan benefits. For a more detailed description of coverage, benefits, limitations and exclusions, please refer to the applicable Certificate of Coverage. Should there be any conflicts between the information contained in this overview and information contained in your Certificate of Coverage, the terms of your Certificate of Coverage will prevail.

| Plan Features | Participating Providers | Nonparticipating Providers |
|---|---|---|
| **Annual Deductible per Member**<br>Copays do not apply toward satisfying any deductible, but do apply toward your annual out-of-pocket-maximum | $1,000, with a two-deductible family maximum | |
| **Out-of-Network Deductible**<br>Applied separately from Annual Deductible | N/A | $2,000 deductible for out-of-network services per member, per year |
| **Annual Out-of-Pocket Maximum**<br>Does not include deductibles | $2,000 per member;<br>$4,000 per family | $10,000 per member;<br>$20,000 per family |
| **Office Visits**<br>Includes X-rays and lab work performed by the physician on the same date of service | Member pays a $35 copay; unlimited visits with deductible waived | 60% |
| **Preventive Care for Adults**<br>Office visits and examinations associated with the preventive care services listed below | Member pays a $35 copay; unlimited visits with deductible waived | 60% |
| • Colorectal cancer screening<br>• Annual Pap smears<br>• Annual mammograms<br>• PSAs<br>• Osteoporosis screenings<br>• Ovarian cancer screenings | 100%; with deductible waived | 60% |
| **Preventive Care for Babies and Children**<br>(Through age 6)<br>• Examinations and office visits related to preventive care | Member pays a $35 copay; unlimited visits with deductible waived | 60% |
| • Immunizations | 100%; with deductible waived | 60% |
| • Lab work/X-rays | 100%; with deductible waived | 60% |
| **Other Preventive Care Services**<br>(Age 7 through adult)<br>Flu shots and routine physical exams that do not directly treat an illness or injury | 100%; (with a maximum covered expense of $300 per member, per year, participating and nonparticipating providers combined); deductible waived | 60%; (with a maximum covered expense of $300 per member, per year, participating and nonparticipating providers combined) |
| **Professional Services**<br>Including surgery, anesthesia, radiation therapy, in-hospital doctor visits, and diagnostic X-ray/lab | 80% | 60% |
| **Lab Work and X-rays** | 80% | 60% |
| **Maternity** | 80% | 60% |
| **Outpatient Medical Care**[4] | 80% | 60% |
| **Physical/Occupational Therapy** | 80%<br>Maximum of 20 visits per member, per year, for all of these services, participating and nonparticipating providers combined | 60% |
| **Mental, Emotional or Functional Nervous Disorders and Alcoholism***<br>**Inpatient hospital charges**[1]<br>Maximum payment of up to $3,000 per member, per year, for participating and nonparticipating providers combined<br>*Exception: Inpatient treatment of alcoholism is payable as any other medical condition | Up to $100 per day | |
| **In- or outpatient professional charges**<br>Maximum of 12 visits per member, per year, for participating and nonparticipating providers combined | Up to $30 per visit | |

# Illinois Premier Flex Plus 1000-80 Plan (cont.)

| Plan Features | Participating Providers | Nonparticipating Providers |
|---|---|---|
| **Smoking Cessation** | $50 for pharmaceuticals and $50 for other covered services per member, per lifetime | |
| **Infusion Therapy**[2,3] | 80% | 60% |
| **Durable Medical Equipment** | 80% | 60% |
| **Inpatient Hospital Services**[1] | 80% | 60% less a $500 copay for nonemergency stays |
| **Inpatient Medical Emergency**[1] | 80% | 80% until transferable to a participating hospital; if stay continues thereafter, 60% of covered expense (after member pays a $500 copay) |
| **Outpatient Hospital Services** | 80% | 60% |
| **Emergency Room Services**<br>Physician, facility and ancillary services | Member pays a $150 copay; with deductible waived | 60% |
| **Ambulatory Surgical Center**[4] | 80% | 60% |
| **Ambulance Service**<br>Maximum covered expense of:<br>$5,000 per trip for air<br>$1,000 per trip for ground | 80% | 60% |
| **Home Health Care**[3]<br>Up to 60 visits per member, per year, for participating and nonparticipating providers combined | 80% | 60% |
| **Skilled Nursing Facilities**[3]<br>Maximum covered expense of $400 per day; up to 100 days per member, per year, for participating and nonparticipating providers combined | 80% | 60% |
| **Hospice**[3]<br>Maximum covered expense of $10,000 per lifetime for participating and nonparticipating providers combined | 80% | 60% |
| **Prescription Drug Deductible** | None | |
| **Prescription Drugs**[5] | | |
| **Retail Pharmacy**<br>Per prescription (up to a 30-day supply) | | |
| **Generic Drugs** | Member pays a $15 copay | 50% of the average wholesale price |
| **Brand Name Formulary Drugs** | Member pays a $30 copay | 50% of the average wholesale price |
| **Brand Name Nonformulary Drugs** | Member pays a $45 copay | 50% of the average wholesale price |
| **Self-Injectable Drugs**[6] | Member pays 20% | Member pays 40% of the average wholesale price |
| **Mail Order**<br>Per prescription (up to a 90-day supply) | | |
| **Generic Drugs** | Member pays a $30 copay | Not available |
| **Brand Name Formulary Drugs** | Member pays a $60 copay | Not available |
| **Brand Name Nonformulary Drugs** | Member pays a $90 copay | Not available |
| **Optional Mental Health Rider**<br>If chosen, this rider replaces the mental health benefit provided with any of the medical plans<br>Maximum payment of $10,000 per insured person, per year for inpatient and professional services, for participating and nonparticipating providers combined | 50% of inpatient hospital charges<br>50% of professional charges | |

1 Inpatient medical care requires preservice benefit review or you will be subject to a $500 copay. This copay is waived on emergency admissions, however, utilization review is still required.

2 To receive maximum benefits, infusion therapy must be authorized by UniCare.

3 In addition to preservice review, certain services require authorization to be eligible for maximum benefits. This applies to organ/tissue transplants, infusion therapy, home health services, skilled nursing facilities, and hospice. Failure to obtain authorization will result in a $1,000 copay.

4 All surgical services of an ambulatory surgical center require preservice benefit review or you will be subject to a $50 copay. Ambulatory surgical centers must be licensed and accredited, and meet all requirements of state and local laws and agencies.

5 Certain prescription drugs, including self-injectable drugs and injectable drugs administered in an outpatient setting, may require prior authorization. Benefits will be denied if you fail to obtain prior authorization.

6 Self-injectable drugs purchased through Mail Service Participating Pharmacy Program are covered at the same level as self-injectables purchased at a retail pharmacy.