Molina Healthcare of Idaho
Gold Value Plus with Adult Vision

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026 – 12/31/2026
Coverage for: Individual & Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at MolinaMarketplace.com or call 1-833-657-1981. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318- 2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $2,250 individual / $4,500 family; for out-of-network providers $20,300 individual / $40,600 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in the chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $8,000 individual / $16,000 family; for out-of-network providers $101,500 individual / $203,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See MolinaMarketplace.com or call 1-833-657-1981 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay/visit deductible does not apply	60% coinsurance	None
	Specialist visit	$60 Copay/visit deductible does not apply	60% coinsurance	Preauthorization may be required, or services not covered.
	Preventive care/screening/immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay for blood work, deductible does not apply 20% Coinsurance/test for x-rays	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	60% coinsurance	Preauthorization is required or Imaging services are not covered
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MolinaMarketplace.com/IDFormulary2026	Generic drugs - preferred	$5 Copay/prescription deductible does not apply	60% coinsurance	Preauthorization may be required, or services may be not covered. Certain prescription drugs are available for up to a 90-day extended supply at network retail pharmacies or a mail order option. Cost sharing for an extended supply is three times (3x) the 30-day retail cost sharing. Mail order not available for Specialty drugs. For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug cost-sharing assistance
	Preferred brand drugs	$75 Copay/prescription	60% coinsurance	
	Non-preferred brand drugs and non-preferred generic drugs	50% Coinsurance/ prescription	60% coinsurance	
	Specialty drugs	50% Coinsurance/ prescription	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				will not apply toward any deductibles or annual out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	60% coinsurance	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% Coinsurance	60% coinsurance	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% coinsurance	Cost-sharing for emergency room care does not apply if admitted to the hospital.
	Emergency medical transportation	20% Coinsurance	20% coinsurance	None.
	Urgent care	$40 Copay deductible does not apply	60% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	60% coinsurance	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% Coinsurance	60% coinsurance	Preauthorization may be required, or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copay/visit deductible does not apply 20% Coinsurance Outpatient Intensive Treatment Program	60% coinsurance	None
	Inpatient services	20% Coinsurance	60% coinsurance	Preauthorization is required for inpatient care or services not covered.
If you are pregnant	Office visits	No charge	60% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	60% coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	60% coinsurance	
If you need help recovering or have other special health	Home health care	20% Coinsurance	60% coinsurance	Services must be provided by a home health agency. Preauthorization may be required, or services may be not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs	Rehabilitation services	20% Coinsurance	60% coinsurance	20 visits/calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% Coinsurance	60% coinsurance	Preauthorization may be required, or services not covered.
	Skilled nursing care	20% Coinsurance	60% coinsurance	30 visits/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	20% Coinsurance	60% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	60% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	60% coinsurance	Coverage limited to one exam/year.
	Children's glasses	No charge	60% coinsurance	Coverage limited to one pair of glasses (lenses and frames) or contact lenses in lieu of prescription glasses/year. Laser corrective surgery not covered.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Infertility Treatment
- Bariatric Surgery
- Cosmetic Surgery
- Treatment for Temporomandibular Joint Disorders
- Long Term/Custodial Nursing Home Care
- Hearing Aids
- Acupuncture
- Abortion (except in cases of rape, incest or to save the life of the mother)
- Private Duty Nursing
- Routine Foot Care Not Related to Diabetes Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Allergy Testing
- Routine Adult Vision

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Idaho Department of Insurance at 1-800-721-3272 or at doi.idaho.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Molina Customer Service at 1-833-657-1981 or the Idaho Department of Insurance at 1-800-721-3272.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-657-1981

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,250**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,250
Copayments	$500
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,550**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,250**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,250
Copayments	$900
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,250**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,450**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Notice – Section 1557
Molina Healthcare of Idaho - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin, race, or sex.

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes:(1) Qualified interpreters. (2) Written Information in other formats, such as large print, audio, accessible electronic formats, and Braille.

- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes:(1) Qualified oral interpreters. (2) Information translated in your language.

If you need these services, contact Molina Member Services at 1-833-657-1981 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at MolinaHealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate, Suite 100
Long Beach, CA 90802
Email: Civil.Rights@MolinaHealthcare.com
Website: MolinaHealthcare.Alertline.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019

TTY/TDD: 800-537-7697

Complaint forms are available here: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

Notice of Availability – Section 1557
Molina Healthcare of Idaho - Marketplace

English	For free language assistance services, and auxiliary aids and services, call 1-833-657-1981 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-833-657-1981 (TTY: 711).
Chinese (Traditional) 中文（台灣繁體）	如需免費的語言協助服務以及輔助裝置和服務，請致電 1-833-657-1981（聽障專線：711）。
Serbo-Croatian Srpski	За бесплатну помоћ у вези са језиком и помагала и услуге, позовите 1-833-657-1981 (TTY: 711).
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-833-657-1981 (TTY: 711)로 연락 주시기 바랍니다.
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-833-657-1981 (TTY: 711).
Arabic العربية	اتصل عىل الرقم 1-833-657-1981(الهاتف النص 711 :((TTY) لتليق خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإلضافية.
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-833-657-1981 (TTY: 711).
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-833-657-1981 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-833-657-1981 (телетайп: 711).
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-833-657-1981 (ATS : 711).
Japanese 日本語	無料の言語サポートや補助器具・サービスをご希望の方は、1-833-657-1981（TTY: 711）までお電話ください。
Romanian Română	Pentru servicii de asistență lingvistică și servicii și ajutor suplimentar, apelați 1-833-657-1981 (TTY: 711).

Sudan العربية السودانية	لخدمات المساعدة اللغوية، وخدمات وأجهزة دعم ذوي االحتياجات الخاصة، يربج االتصال عىل 1-833-657-1981 (رقم الهاتف النص: ١١٧). برای دریافت خدمات کمک زبا ن رایگان، وکمکها و خدمات اضا ف با این شماره تماس بگ یید: 1-833-657-1981 (TTY: 711).
Persian فارىس	
Ukranian Українська	Для отримання безкоштовної мовної допомоги, допоміжних засобів та послуг телефонуйте за номером 1-833-657-1981 (TTY: 711).