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, www.MolinaMarketplace.com 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 1-833-644-1623 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,300 / individual or $2,600 / family Combined Medical and Rx	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. Yes. Preventive care, office visits, urgent care, lab work, rehabilitation services, habilitation services, home healthcare and preferred generic & brand drugs are covered before you meet your deductible.	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 provider $3,150 Individual or $6,300 /family; for out-of-network provider, there is no coverage unless Prior Authorized by Molina Healthcare.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have oth 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 Molina Marketplace network at MolinaMarketplace.com/ILFindCare or call 1-833-644-1623 for a list of network provider.	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.
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.

What You Will Pay				
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay /office visit	Not covered	No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse.
	Specialist visit	$15 copay /visit	Not covered	Preauthorization may be required, or services not covered.
	Preventive care/screening/ immunization	No Charge	Not covered	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)	20% coinsurance after deductible /test for x- rays; 20% coinsurance after deductible /test for blood	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible /test	Not covered	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 MolinaMarketplace.com/ILFormulary2024	Generic drugs - Preferred	Retail:$5 copay /prescription; Mail:$12.50 cost share for 90-day supply	Not covered	Preauthorization may be required or services may not be covered. Mail-order Prescription Drugs are available at a 90-day supply and is offered at two and a half times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance
	Preferred brand drugs	Retail:$50 copay /prescription ; Mail:$125 copay cost share for 90-day supply	Not covered	
	Non-Preferred drugs	Retail: 20% coinsurance after deductible /prescription ; Mail: 20% coinsurance cost share after deductible for 90-	Not covered	
	Specialty drugs	20% coinsurance after deductible /prescription	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.Molinahealthcare.com

What You Will Pay				
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible for facility /day	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% coinsurance after deductible /day	Not covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible /visit	20% coinsurance after deductible /visit	Emergency room care copay does not apply, if admitted to the hospital.
	Emergency medical transportation	20% coinsurance after deductible /trip	20% coinsurance after deductible /trip	
	Urgent care	$13 copay /visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible /day	Not covered	Preauthorization is required, or services not covered. Maximum two days of facility Copayments per inpatient admission.
	Physician/surgeon fees	20% coinsurance after deductible /visit	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay /office visit	Not covered	No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse. Preauthorization is required, or services not covered. Maximum two days of facility Copayments per inpatient admission.
	Inpatient services	20% coinsurance after deductible /day	Not covered	
If you are pregnant	Office visits	No Charge	Not covered	Cost sharing does not apply to routine prenatal care and first post-natal visit and certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible /visit	Not covered	
	Childbirth/delivery facility services	20% coinsurance after deductible /day	Not covered	
If you need help recovering or have other special needs	Home health care	No Charge	Not covered	Preauthorization may be required, or services not covered. Services must be provided by an in network Home health agency.
	Rehabilitation services	20% coinsurance after deductible /visit	Not covered	Preauthorization may be required, or services not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.Molinahealthcare.com

What You Will Pay				
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
	Habilitation services	20% coinsurance after deductible /visit	Not covered	Preauthorization may be required, or services not covered
	Skilled nursing care	20% coinsurance after deductible per day	Not covered	Preauthorization is required, or services not covered.
	Durable medical equipment	20% coinsurance after deductible /request	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required, or services not covered
	Hospice services	No Charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Children up to age 19.Coverage limited to one exam/year.
	Children's glasses	No Charge	Not covered	Children up to age 19.Coverage limited to one pair of glasses/year.
	Children's dental checkups	Not Covered	Not covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

* For more information about limitations and exceptions, see the plan or policy document at www.Molinahealthcare.com

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.)

- Acupuncture
- Dental Care (Adult)
- Dental Care (Child)
- Long-Term Care
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Weight Loss Programs

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

- Abortion care
- Bariatric Surgery
- Chiropractic Care (limited to 25 visits per year)
- Cosmetic Surgery (Correction of congenital deformities, or conditions from accidental injuries, scars, tumors, or disease)
- Hearing Aids (under 18 year of age -1 hearing aid per ear every 36 months; over 18 years of age 1 hearing aid per ear every 24 months)
- Infertility treatment (see Agreement for coverage details)
- Private Duty Nursing (Medically Necessary)
- Routine Foot Care (For diabetes treatments)

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: Molina Healthcare of Illinois at 1-833-644-1623 or Illinois Department of Insurance at 1-877-527-9431. 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 Healthcare of Illinois at 1-833-644-1623 or Illinois Department of Insurance at 1-877-527-9431.

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? Yes

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 1-833-644-1623.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-644-1623.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-644-1623.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-644-1623.

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 $1,300
- Specialist copay $15
- Hospital (facility) coinsurance per day after deductible 20%
- Other coinsurance after deductible 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	$1,300
Copayments	$20
Coinsurance	$1,800

What isn't covered	
Limits or exclusions	$0

The total Peg would pay is	**$3,120**

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

- The plan's overall deductible $1,300
- Specialist copay $15
- Hospital (facility) coinsurance per day after deductible 20%
- Other coinsurance after deductible 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	$900
Copayments	$900
Coinsurance	$0

What isn't covered	
Limits or exclusions	$0

The total Joe would pay is	**$1,800**

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

- The plan's overall deductible $1,300
- Specialist copay $15
- Hospital (facility) coinsurance per day after deductible 20%
- Other coinsurance after deductible 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	$1,300
Copayments	$50
Coinsurance	$200

What isn't covered	
Limits or exclusions	$0

The total Mia would pay is	**$1,550**

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

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge, in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802. You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at:https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html You can mail it to:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
If you need help, call (800) 368-1019; TTY (800) 537-7697.

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ATTENTION: Aids and services for people with disabilities, like documents in braille and large print, are also available. If you need help in your language call Member Services located on back of your ID card. (TTY: 711). These services are free of charge.

ATENCIÓN: Si necesita ayuda en su idioma llame a Servicios para Miembros. El número está en el reverso de su tarjeta de identificación de miembro. (TTY: 711). También hay disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Estos servicios son gratuitos. (Spanish)

تنبيه: إذا كنت بحاجة إلى مساعدة في لغتك ، فاتصل بخدمات الأعضاء. الرقم موجود على ظهر بطاقة هوية العضو الخاصة بك.
(الهاتف النصي: 711). تتوفر أيضا مساعدات وخدمات للأشخاص ذوي الإعاقة ، مثل المستندات بطريقة برايل والطباعة الكبيرة. هذه الخدمات مجانية. (Arabic)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք Member Services: Համարը գտնվում է ձեր Member ID քարտի ետեւի մասում: (TTY: 711):
Առկա են նաեւ հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ եւ ծառայություններ, ինչպես բրեյլի եւ մեծ տպաքանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចិត្តទុកដាក់៖ ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការក៏មានផងដែរ,
ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅទាសារបស់អ្នកថាសមាជិកសេវាកម្មនៃលេខមានទីតាំងនៅខាងក្រោយអត្តសញ្ញាណប័ណ្ណរបស់អ្នក. (TTY: ៧១១). សេវាកម្មទាំងនេះគឺឥតគិតថ្លៃ. (Cambodian)

注意：如果您需要语言方面的帮助，请致电会员服务部。该号码位于您的会员 ID 卡背面。(TTY: 711)。
还为残疾人提供辅助工具和服务，如盲文和大字体文件。这些服务是免费的。(Chinese Simplified)

توجه: کمک ها و خدمات برای افراد معلول، مانند اسناد بریل
و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود تماس بگیرید.
(TTY: 711). این خدمات رایگان هستند. (Farsi)

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो सदस्य सेवाओं को कॉल करें। नंबर आपके सदस्य आईडी कार्ड के पीछे है। (TTY: 711)
। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज, भी उपलब्ध हैं। ये सेवाएं नि: शुल्क हैं। (Hindi)

XIM: Yog koj xav tau kev pab los ntawm koj cov kev pab. Tus naj npawb nyob sab nraum qab ntawm koj tus ID card. (TTY: 711).
Aids thiab kev pab rau cov neeg uas muaj mob xiam oob qhab, xws li cov ntaub ntawv nyob rau hauv braille thiab loj print, kuj muaj. Cov kev pab no yog pab dawb xwb. (Hmong)

ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, rufen Sie den Mitgliederservice an. Die Nummer finden Sie auf der Rückseite Ihres Mitgliedsausweises. (TTY: 711).
Hilfsmittel und Dienstleistungen für Menschen mit Behinderungen, wie Dokumente in Blindenschrift und Großdruck, sind ebenfalls verfügbar. Diese Dienstleistungen sind kostenlos. (German)

注意：あなたの言語で助けが必要な場合は、メンバーサービスに電話してください。番号は会員証の裏面に記載されています。(TTY: 711)。
点字や大活字の書類など、障害者のための援助やサービスも利用できます。これらのサービスは無料です。 (Japanese)

주의: 귀하의 언어로 도움이 필요하면 회원 서비스에 전화하십시오. 이 번호는 가입자 ID 카드 뒷면에 있습니다. (TTY: 711)
입니다. 점자 및 큰 활자로 된 문서와 같은 장애인을 위한 보조 및 서비스도 제공됩니다. 이러한 서비스는 무료입니다. (Korean)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese

ຂໍ້ຄວນລະວັງ: Aids ແລະການບໍລິການສໍາລັບຄົນພິການ, ເຊັ່ນດຽວກັບເອກະສານໃນ braille ແລະການພິມຂະຫນາດໃຫຍ່, ຍັງມີ.
ຖ້າ ທ່ານ ຕ້ອງ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ ທ່ານ .
(TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

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attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਮੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711).
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711).
Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print.
Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711).
Ang mga serbisyong ito ay libre. (Tagalog)

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโทรติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711)
นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711).
Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).
Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese