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?	$2,100 / individual or $4,200 / 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 $8,550 Individual or $17,100/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 MolinaMarketplace.com 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	None
	Specialist visit	$50 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; $15 copay /test for blood work	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 www.molinamarketplace/ILFormulary2022.com	Preferred Generic Drugs (Tier-1)	Retail:$10 copay /prescription deductible does not apply; Mail:$20 cost share for 90-day supply deductible does not apply	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 times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance
	Preferred Brand Drugs (Tier-2)	Retail:$50 copay /prescription deductible does not apply ; Mail:$100 cost share for 90-day supply deductible does not apply	Not covered	
	Non-Preferred Brand and Generic Drugs (Tier-3)	Retail:30% coinsurance after deductible ; Mail:2x cost share of 30% after deductible for 90-day supply	Not covered	
	Brand and Generic Specialty drugs (Tier-4)	30% coinsurance after deductible	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	$10 copay /visit	$10 copay /visit	
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	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	$50 copay /visit	Not covered	Preauthorization may be required, or services not covered.
	Habilitation services	$50 copay /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**
	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.

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
- 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 eye care (Adult)
- Routine Foot Care (For diabetes treatments)

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

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	$2,100
Specialist copay	$50
Hospital (facility) coinsurance per day after deductible	20%
Other coinsurance	0%

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	$2,100
Copayments	$300
Coinsurance	$1,900

What isn't covered	
Limits or exclusions	$0

The total Peg would pay is	**$4,300**

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

The plan's overall deductible	$2,100
Specialist copay	$50
Hospital (facility) coinsurance per day after deductible	20%
Other coinsurance	0%

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	$800
Copayments	$600
Coinsurance	$0

What isn't covered	
Limits or exclusions	$0

The total Joe would pay is	**$1,400**

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

The plan's overall deductible	$2,100
Specialist copay	$50
Hospital (facility) coinsurance per day after deductible	20%
Other coinsurance	0%

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	$1,700
Copayments	$400
Coinsurance	$0

What isn't covered	
Limits or exclusions	$0

The total Mia would pay is	**$2,100**

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