
 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](http://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](http://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 <a href="#">deductible</a> ?	\$0 / individual or \$0 / family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All covered medical services and preferred generic & brand drugs are covered before you meet your <a href="#">prescription drug</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$1,350 Individual or \$2,700/family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network provider</a> \$8,550 Individual or \$17,100/family; for <a href="#">out-of-network provider</a> , there is no coverage unless Prior Authorized by Molina Healthcare.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://MolinaMarketplace.com">MolinaMarketplace.com</a> or call 1-833-644-1623 for a list of <a href="#">network provider</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit	Not covered	None
	<a href="#">Specialist</a> visit	\$90 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$135 /test for x- rays; \$50 <a href="#">copay</a> /test for blood work	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$700 <a href="#">copay</a> /test	Not covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.molinamarketplace/ILFormulary2022.com">www.molinamarketplace/ILFormulary2022.com</a>	Preferred Generic Drugs (Tier-1)	Retail:\$30 <a href="#">copay</a> /prescription <a href="#">deductible</a> does not apply; Mail:\$60 cost share for 90-day supply <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> may be required or services may not be covered. Mail-order <a href="#">Prescription Drugs</a> are available at a 90-day supply and is offered at two times the 30-day retail prescription <a href="#">Cost Sharing</a> . Depending on Tier level this will be either a <a href="#">Copayment</a> or a <a href="#">Coinsurance</a>
	Preferred Brand Drugs (Tier-2)	Retail:\$100 <a href="#">copay</a> /prescription <a href="#">deductible</a> does not apply; Mail:\$200 cost share for 90-day supply <a href="#">deductible</a> does not apply	Not covered	
	Non-Preferred Brand and Generic Drugs (Tier-3)	Retail:40% <a href="#">coinsurance</a> after <a href="#">deductible</a> ; Mail:2x cost share of 40% after <a href="#">deductible</a> for 90-day supply	Not covered	
	Brand and Generic <a href="#">Specialty drugs</a> (Tier-4)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.Molinahealthcare.com](http://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)	\$150 <a href="#">copay</a> for facility /day	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	Physician/surgeon fees	\$105 <a href="#">copay</a> /day	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$1,250 <a href="#">copay</a> /visit	\$1,250 <a href="#">copay</a> /visit	<a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a> /trip	\$150 <a href="#">copay</a> /trip	
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /visit	\$30 <a href="#">copay</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 <a href="#">copay</a> /day	Not covered	<a href="#">Preauthorization</a> is required, or services not covered. Maximum two days of facility <a href="#">Copayments</a> per inpatient admission.
	Physician/surgeon fees	\$90 <a href="#">copay</a> /visit	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /office visit	Not covered	<a href="#">Preauthorization</a> is required, or services not covered. Maximum two days of facility <a href="#">Copayments</a> per inpatient admission.
	Inpatient services	\$600 <a href="#">copay</a> /day	Not covered	
If you are pregnant	Office visits	No Charge	Not covered	<a href="#">Cost sharing</a> does not apply to routine prenatal care and first post-natal visit and certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Maximum two days of facility <a href="#">Copayments</a> per admission.
	Childbirth/delivery professional services	\$90 <a href="#">copay</a> /visit	Not covered	
	Childbirth/delivery facility services	\$600 <a href="#">copay</a> /day	Not covered	
If you need help recovering or have other special needs	<a href="#">Home health care</a>	No Charge	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered. Services must be provided by an <a href="#">network</a> Home health agency.
	<a href="#">Rehabilitation services</a>	\$60 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Habilitation services</a>	\$60 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered

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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
	<a href="#">Skilled nursing care</a>	\$600 <a href="#">copay</a> per day	Not covered	<a href="#">Preauthorization</a> is required, or services not covered.
	<a href="#">Durable medical equipment</a>	\$150 <a href="#">copay</a> /request	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> may be required, or services not covered
	<a href="#">Hospice services</a>	No Charge	Not covered	None
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Child)</li> <li>Long-Term Care</li> <li>Non-emergency care when traveling outside the U.S</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion care</li> <li>Bariatric Surgery</li> <li>Chiropractic Care (limited to 25 visits per year)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (Correction of congenital deformities, or conditions from accidental injuries, scars, tumors, or disease)</li> <li>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)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (see Agreement for coverage details)</li> <li>Private Duty Nursing (<a href="#">Medically Necessary</a>)</li> <li>Routine Foot Care (For diabetes treatments)</li> </ul>

**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

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**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, kwijigo 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](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copay](#) per day \$1,200
- 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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$0

What isn't covered	
Limits or exclusions	\$0

**The total Peg would pay is \$1,600**

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copay](#) per day \$1,200
- 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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$0

What isn't covered	
Limits or exclusions	\$0

**The total Joe would pay is \$1,600**

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copay](#) per day \$1,200
- 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	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,500
<a href="#">Coinsurance</a>	\$0

What isn't covered	
Limits or exclusions	\$0

**The total Mia would pay is \$1,500**

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.