




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 1-888-296-7677. 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? | \$1,750 / individual or \$3,500 / family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. <u>Preventive care</u> , office visits, <u>urgent care</u> , <u>rehabilitation services</u> , <u>habilitation services</u> , <u>diagnostic tests</u> , inpatient services, <u>home healthcare</u> , and preferred generic & brand drugs are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes, \$1,750/individual or \$3,500/family for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For <u>network providers</u> \$7,250 individual / \$14,500 family; for <u>out-of-network providers</u> there is no coverage unless <u>preauthorized</u> by Molina Healthcare. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a network provider? | Yes. See MolinaMarketplace.com or call 1-888-296-7677 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 | \$30 <u>copay</u> /visit | Not covered | None |
| | <u>Specialist</u> visit | \$60 <u>copay</u> /visit | Not covered | <u>Preauthorization</u> may be required, or services not covered. |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | \$60 <u>copay</u> /test for blood work \$95 <u>copay</u> /test for x-rays | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | <u>Preauthorization</u> is required or Imaging services are not covered |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.MolinaMarketplace.com/OHformulary2023 | Generic drugs - Preferred (Tier 1) | \$25 <u>copay</u> /prescription (retail) | Not covered | <u>Preauthorization</u> may be required, or services may be not covered. Up to 30-day supply retail. For tiers 1, 2 and 3, up to 90-day supply by mail order offered at two-and-a-half times the 30-day retail <u>cost-sharing</u> . For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug <u>cost-sharing</u> assistance will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limit</u> . |
| | Preferred brand drugs (Tier 2) | \$60 <u>copay</u> /prescription (retail) | Not covered | |
| | Non-preferred brand drugs and non-preferred generic drugs (Tier 3) | 50% <u>coinsurance</u> after <u>deductible</u> /prescription (retail) | Not covered | |
| | <u>Specialty drugs</u> (Tier 4) | 50% <u>coinsurance</u> after <u>deductible</u> /prescription | Not covered | <u>Preauthorization</u> may be required, or services not covered. Mail order not |

| 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) | |
| | | | | available. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required, or services not covered. |
| | Physician/surgeon fees | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required, or services not covered. |
| If you need immediate medical attention | <u>Emergency room care</u> | \$950 <u>copay</u> | \$950 <u>copay</u> | <u>Cost-sharing for emergency room care</u> does not apply if admitted to the hospital. |
| | <u>Emergency medical transportation</u> | 50% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | <u>Urgent care</u> | \$30 <u>copay/visit</u> | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,200 <u>copay/day</u> (maximum of 2 days) | Not covered | <u>Preauthorization</u> is required or services not covered. Maximum two days of facility <u>copayments</u> per inpatient admission. |
| | Physician/surgeon fees | \$60 <u>copay</u> | Not covered | <u>Preauthorization</u> is required or services not covered. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 <u>copay/visit</u> Outpatient Intensive Treatment Program: 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | None |
| | Inpatient services | \$1,200 <u>copay/day</u> facility (maximum of 2 days); \$60 <u>copay/visit</u> professional fee | Not covered | <u>Preauthorization</u> is required for inpatient care or services not covered. Maximum two days of facility <u>copayments</u> per inpatient admission. |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply to routine prenatal care and first post-natal visit and certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Maximum two days of facility <u>copayments</u> per inpatient admission. |
| | Childbirth/delivery professional services | \$60 <u>copay</u> | Not covered | |
| | Childbirth/delivery facility services | \$1,200 <u>copay</u> per day (maximum of 2 days) | Not covered | |
| If you need help | <u>Home health care</u> | No charge | Not covered | <u>Preauthorization</u> may be required, or |

| 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) | |
| recovering or have other special health needs | | | | <p>services may be not covered. Limited to:</p> <ul style="list-style-type: none"> • Up to 2 hours nursing per visit • Up to 4 hours home health aide per visit • Up to 100 visits per calendar year for all home health visits except private duty nursing. <p>Private duty nursing visits are limited to 90 visits/year. <u>Preauthorization</u> is required after 6 visits for home settings, or services may be not covered.</p> |
| | <u>Rehabilitation services</u> | \$60 <u>copay</u> /visit | Not covered | <p><u>Preauthorization</u> may be required, or services may be not covered. Limited to:</p> <ul style="list-style-type: none"> • Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Therapy: 20 visits per therapy/year • Cardiac Rehabilitation: 36 visits/year • Manipulation Therapy: 12 visits/year |
| | <u>Habilitation services</u> | \$60 <u>copay</u> /visit | Not covered | <u>Preauthorization</u> may be required, or services may be not covered. |
| | <u>Skilled nursing care</u> | \$1,200 <u>copay</u> /day | Not covered | <u>Preauthorization</u> may be required, or services may be not covered. Limited to 90 days/year. |
| | <u>Durable medical equipment</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | <u>Preauthorization</u> may be required, or services may be not covered. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | <u>Hospice services</u> | No charge | Not covered | <u>Preauthorization</u> may be required, or services may be not covered. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge | Not covered | 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 | Not Applicable. Coverage can be purchased as a standalone product; it is not covered by |

| 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) | |
| | | | | this policy. |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|--|---|
| <ul style="list-style-type: none"> • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult) • Dental care (Child) • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine foot care • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) |
|---|
| <ul style="list-style-type: none"> • Chiropractic care • Infertility treatment |

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 Ohio, Inc. (Phone: 1-888-296-7677) or Ohio Department of Insurance (Phone: 1-800-686-1526). 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: Ohio Department of Insurance (Phone: 1-800-686-1526).

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.

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 <u>plan's overall deductible</u> | \$1,750 |
| ■ <u>Specialist copayment</u> | \$60 |
| ■ Hospital (facility) <u>copayment</u> | \$1,200 |
| ■ Other <u>coinsurance</u> | 50% |

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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$2,100 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,100 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$1,750 |
| ■ <u>Specialist copayment</u> | \$60 |
| ■ Hospital (facility) <u>copayment</u> | \$1,200 |
| ■ Other <u>coinsurance</u> | 50% |

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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$800 |
| <u>Copayments</u> | \$1,400 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,200 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$1,750 |
| ■ <u>Specialist copayment</u> | \$60 |
| ■ Hospital (facility) <u>copayment</u> | \$1,200 |
| ■ Other <u>coinsurance</u> | 50% |

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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$1,200 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| 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.



Your Extended Family.

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 <http://www.hhs.gov/ocr/office/file/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.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجاناً لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Չանգահարելիք Հանախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਮੈਂਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)