




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 1-888-858-3973. 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. No Charge for Covered Services at a Participating Indian Health Care Provider (IHCP).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Yes, Individual: \$2,500 Family: \$5,000	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, Office Visits, Inpatient Services, Specialized Scanning Services, Laboratory Tests, Habilitation Services, Rehabilitation Services, Skilled Nursing Facility 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?	Yes, a prescription drug deductible applying to Non-Preferred Brand and Generic Drugs and Specialty Drugs. Individual: \$2,500 Family: \$5,000	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual: \$9,100 Family: \$18,200	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 1-888-858-3973 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

Important Questions	Answers	Why This Matters:
		your <u>provider</u> before you get services.
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 <u>deductible</u> does not apply	Not Covered	None
	<u>Specialist</u> visit	\$60 <u>Copay</u> /visit <u>deductible</u> does not apply	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)	\$95 <u>Copay</u> for x-ray <u>deductible</u> does not apply \$60 <u>Copay</u> for blood work <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> is required or Imaging services are not covered
	Generic drugs - Preferred (Tier 1)	\$29 <u>Copay</u> /prescription <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered. Mail-order <u>Prescription Drugs</u> are available for up to a 90-day supply and is offered at 2.5 times the 30-day retail prescription <u>Cost Sharing</u> . Depending on Tier level this will be either a <u>Copayment</u> or
Preferred brand drugs (Tier 2)	\$60 <u>Copay</u> /prescription <u>deductible</u> does not apply	Not Covered		
Non-preferred brand drugs and non-preferred generic drugs (Tier 3)	50% <u>Coinsurance</u> /prescription	Not Covered		

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

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)	
www.MolinaMarketplace.com/UTFormulary2023	<u>Specialty drugs</u> (Tier 4)	50% <u>Coinsurance</u> /prescription	Not Covered	a <u>Coinsurance</u> . For brand name drugs with a generic equivalent, coupons or any other form of third-party <u>prescription drug</u> cost sharing assistance will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limits</u> . <u>Preauthorization</u> is required, or services not covered. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
	Physician/surgeon fees	50% <u>coinsurance</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> /visit <u>deductible</u> does not apply	\$950 <u>Copay</u> /visit <u>deductible</u> does not apply	<u>Emergency room care cost sharing</u> does not apply, if admitted to the hospital.
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$30 <u>Copay</u> /visit	Not Covered	<u>Preauthorization</u> is required for out-of-area <u>Urgent care</u> services, or services not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,200 <u>Copay</u> /day <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> is required or services not covered. Maximum two <u>copays</u> per admission.
	Physician/surgeon fees	\$60 <u>Copay</u> <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$30 <u>Copay</u> <u>deductible</u> does not apply Professional Fee:	Not Covered	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.MolinaMarketplace.com.

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)	
		50% <u>coinsurance</u> Facility Fee: 50% <u>coinsurance</u>		
	Inpatient services	\$1,200 <u>Copay/day deductible</u> does not apply	Not Covered	<u>Preauthorization</u> is required for inpatient care or services not covered. Maximum two <u>copays</u> per 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). Pregnancy termination services, subject to restrictions and state law. Maximum two <u>copays</u> per admission.
	Childbirth/delivery professional services	\$60 <u>Copay deductible</u> does not apply	Not Covered	
	Childbirth/delivery facility services	\$1,200 <u>Copay/day deductible</u> does not apply	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not Covered	Limited to: • Up to 2 hours nursing per visit • Up to 4 hours home health aide per visit • 30 visits per calendar year <u>Preauthorization</u> is required after 7 visits for home settings, or services may be not covered
	<u>Rehabilitation services</u>	\$60 <u>Copay deductible</u> does not apply	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined
	<u>Habilitation services</u>	\$60 <u>Copay deductible</u> does not apply	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined
	<u>Skilled nursing care</u>	\$1,200 <u>Copay/day deductible</u> does not apply	Not Covered	Limited to 30 days per calendar year. <u>Preauthorization</u> may be required, or services may be not covered.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not Covered	Excludes vehicle modifications, home

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.MolinaMarketplace.com.

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)	
				modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	No charge	Not Covered	Limited to 6 months in a 3-year period. Notification only, <u>Preauthorization</u> is not required.
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/year.
	Children's dental check-up	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 <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 • Routine Foot Care 	<ul style="list-style-type: none"> • Cosmetic Surgery • Dental Care (Adult) • Hearing Aids • Infertility Treatment 	<ul style="list-style-type: none"> • Long-Term Care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Chiropractic care

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"> • Routine eye care (Adult)

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: Utah Insurance Department 1-801-538-3077. 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: Utah Insurance Department 1-801-538-3077.

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

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.

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

About these Coverage Examples:

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.MolinaMarketplace.com.



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](#) \$250
- [Specialist Copayment](#) \$60
- Hospital (facility) [Copayment](#) \$1,200
- Other [Coinsurance](#) 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,100
Coinsurance	\$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 [plan's](#) overall [deductible](#) \$250
- [Specialist Copayment](#) \$60
- Hospital (facility) [Copayment](#) \$1,200
- Other [Coinsurance](#) 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,400
Coinsurance	\$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 [plan's](#) overall [deductible](#) \$250
- [Specialist Copayment](#) \$60
- Hospital (facility) [Copayment](#) \$1,200
- Other [Coinsurance](#) 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$900
Coinsurance	\$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 Հանախորհրդների 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)