MOLINA HEALTHCARE

Molina Healthcare of Utah, Inc.: Silver 1 150 with Adult Vision Services

Coverage Period: 01/01/2025 – 12/31/2025

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage for: Individual + Family | Plan Type: HMO**

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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: $850 Family: $1,700	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 and services indicated in the chart starting on page 2.	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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Individual: $2,825 Family: $5,650	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/UTFindCare 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

Important Questions	Answers	Why This Matters:
		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.

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	$8 Copay/visit deductible does not apply	Not Covered	None
	Specialist visit	$30 Copay/visit deductible does not apply	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$75 Copay for x-ray deductible does not apply $30 Copay for blood work deductible does not apply	Not Covered	Preauthorization may be required, or services not covered.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	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.	Generic drugs - preferred	$5 Copay/prescription (retail) deductible does not apply	Not Covered	Preauthorization may be required, or services not covered. Mail-order Prescription Drugs are available for up to a 90-day supply and is offered at 3 times the 30-day retail prescription Cost Sharing. Mail order not available for Specialty drugs. Depending on Tier level this will be either a Copayment or a Coinsurance.
	Preferred brand drugs	$65 Copay/prescription (retail) deductible does not apply	Not Covered	
	Non-preferred brand drugs	30% Coinsurance	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)	
com/UTFormulary2025	and non-preferred generic drugs	/prescription (retail)		For brand name drugs with a generic equivalent, coupons or any other form of third-party prescription drug cost sharing assistance will not apply toward any deductibles or annual out-of-pocket limits.
	Specialty drugs	30% Coinsurance /prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	30% coinsurance	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Emergency room care cost sharing does not apply, if admitted to the hospital.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$25 copay/visit deductible does not apply	Not Covered	Preauthorization is required for out-of-area Urgent care services, or services not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	30% coinsurance	Not Covered	Preauthorization is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $8 Copay deductible does not apply Professional Fee: 30% coinsurance Facility Fee: 30% coinsurance	Not Covered	None
	Inpatient services	30% coinsurance	Not Covered	Preauthorization is required for inpatient care or services not covered.

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 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). Pregnancy termination services, subject to restrictions and state law.
	Childbirth/delivery professional services	30% coinsurance	Not Covered	
	Childbirth/delivery facility services	30% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	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 Preauthorization is required after 7 visits for home settings, or services may be not covered.
	Rehabilitation services	$30 Copay deductible does not apply	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined
	Habilitation services	$30 Copay deductible does not apply	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy combined
	Skilled nursing care	30% coinsurance	Not Covered	Limited to 30 days per calendar year. Preauthorization may be required, or services may be not covered.
	Durable medical equipment	30% coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	Not Covered	Limited to 6 months in a 3-year period. Notification only, Preauthorization 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

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)	
				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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Routine Foot Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- 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 plan document.)

- 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.

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:

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	**$850**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$850
Copayments	$600
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,825**

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

The plan's overall deductible	**$850**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	**$850**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$850
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

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

Non-Discrimination Notice – Section 1557
Molina Healthcare - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin (including limited English proficiency), race, or sex (consistent with the scope of sex discrimination described at § 92.101(a)).

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes: (1) Qualified interpreters. (2) Information in other formats, such as large print, audio, accessible electronic formats, Braille.
- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes: (1) Qualified oral interpreters. (2) Information translated in your language.

If you need these services, contact Molina Member Services at 1-888-858-3973 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate
Long Beach, CA 90802
Email: civil.rights@molinahealthcare.com
Website: https://molinahealthcare.Alertline.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019
TTY/TDD: 800-537-7697

Complaint forms are available here: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

English	For free language assistance services, and auxiliary aids and services, call 1-888-858-3973 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-858-3973 (TTY: 711).
Chinese 中文（简体）	如需免费的语言协助服务以及辅助工具和服务，请致电1-888-858-3973（TTY 用户请拨打 711）。
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-888-858-3973 (TTY: 711).
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-888-858-3973 (TTY: 711)로 연락 주시기 바랍니다.
Navajo Diné	T'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í, dóó bee ahxił hane'í ádaat'éhígíí dóó bee áka'nída'awo'í biniiyégo, kohjį' hodíilnih 1-888-858-3973 (TYY: 711).
Nepali नेपाली	भाषासम्बन्धी निःशुल्क सहायता सेवा र अतिरिक्त सहायता तथा सेवाहरूका लागि 1-888-858-3973 (TTY: 711) मा कल गर्नुहोस्।
Tongan Tonga	Ke ma'u 'a e tokoni ki he lea fakafonua ta'etotongi, mo e ngaahi tokoni mo e ngaahi tokoni 'a e houalotu, telefoni ki he 1-888-858-3973 (TTY: 711).
Serbo-Croatian Srpski	За бесплатну помоћ у вези са језиком и помагала и услуге, позовите 1-888-858-3973 (TTY: 711).
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-858-3973 (TTY: 711).
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-858-3973 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-858-3973 (телетайп: 711).

Arabic العربية	اتصل على الرقم 1-888-858-3973 (الهاتف النصي (TTY): 711)) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Mon-Khmer Cambodian ខ្មែរ	សម្រាប់សេវាកម្មជំនួយភាសា និងជំនួយផ្នែកស្តាប់ដោយឥតគិតថ្លៃ សូមទូរសព្ទទៅ 1-888-858-3973 (TTY: 711)។
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-858-3973 (ATS : 711).
Japanese 日本語	無料の言語サポートや補助器具・サービスをご希望の方は、1-888-858-3973（TTY: 711）までお電話ください。