This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.molinahealthcare.com or by calling 1-888-858-2150.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual **$0**/ Family of 2 or more **$0**	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,000** Individual **$8,000** Family of 2 or more	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, go to www.molinahealthcare.com, or call [1-888-665-4621]	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. All services except for females members to see an OB/GYN, family planning services, HIV testing and counseling, minor consent services, and services for sexually transmitted diseases.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-858-2150 or visit us at www.molinahealthcare.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/cciio/ or call 1-888-858-2150 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use an Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	Not Covered	----------none----------
	Specialist visit	$40 Copay per visit	Not Covered	Prior authorization may be required, or services not covered.
	Other practitioner office visit	$20 Copay per visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$20 Copay	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.molinhealthcare.com.	Generic drugs	$5 Copay	Not Covered	----------none----------
	Preferred brand drugs	$15 Copay	Not Covered	----------none----------
	Non-preferred brand drugs	$25 Copay	Not Covered	----------none----------
	Specialty drugs	10% Coinsurance	Not Covered	Prior authorization is required, or services not covered. Up to $250 per script; Maximum Cost Sharing of $200 for a 30-day supply of oral chemotherapy drugs.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use an Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not Covered	Prior authorization may be required, or services not covered.
	Physician/surgeon fees	10% Coinsurance	Not Covered	
If you need immediate medical attention	Emergency room services	$150 Copay per visit	$150 Copay per visit	This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to "If you have a hospital stay", for applicable costs)
	Emergency medical transportation	$150 Copay	$150 Copay	----------none----------
	Urgent care	$40 Copay per visit	$40 Copay per visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
	Physician/surgeon fee	10% Coinsurance	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Copay per visit (individual, group evaluation, counseling, intensive outpatient, day treatment programs)	Not Covered	Prior authorization may be required, or services not covered.
	Mental/Behavioral health inpatient services	10% Coinsurance	Not Covered	
	Substance use disorder outpatient services	$20 Copay per visit (individual, group evaluation, counseling, intensive outpatient, day treatment programs)	Not Covered	
	Substance use disorder inpatient services	10% Coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	----------none----------
	Delivery and all inpatient services	10% Coinsurance	Not Covered	Prior notification is required, for services not covered. Pregnancy termination services are subject to restrictions and state law

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use an Non-Participating Provider	Limitations & Exceptions
ou need help recovering or have other special health needs	Home health care	10% Coinsurance	Not Covered	Limited to: • Up to two (2) hours per visit for visits by a nurse, medical social worker, or physician, occupational, or speech therapist, and up to four (4) hours per visit by a home health aide • Up to one-hundred (100) visits per calendar year (counting all home health visits) Prior authorization is required, or services not covered.
	Rehabilitation services	$20 Copay per visit	Not Covered	Prior authorization is required, or services not covered.
	Habilitation services	$20 Copay per visit	Not Covered	Prior authorization is required, or services not covered.
	Skilled nursing care	10% Coinsurance	Not Covered	Limited to one-hundred (100) days per calendar year. Prior authorization is required, or services not covered.
	Durable medical equipment	10% Coinsurance	Not Covered	Prior authorization is required for durable medical equipment over $500, or services not covered.
	Hospice service	0% Coinsurance	Not Covered	Prior notification is required.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use an Non-Participating Provider	Limitations & Exceptions
	Glasses	$0 Copay	Not Covered	Limited to: • Prescription glasses (frames and lenses) limited to one pair of prescription glasses once every 12 months • Contact Lenses: limited to once every 12 months, in lieu of prescription glasses
	Dental check-up	No Charge	Not Covered	Plan pays 100% preventive examinations twice per calendar year. See your policy or plan document for additional information about services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic 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
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [1-888-665-4621]. You may also contact your state insurance department at 1-888-466-2219.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: [1-888-665-4621]. Additionally, a consumer assistance program can help you file your appeal. Contact 1-888-466-2219.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-888-665-4621].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-888-665-4621].]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [1-888-665-4621].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-888-665-4621].]

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,040
- **Patient pays** $3,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$420
Coinsurance	$93
Limits or exclusions	$150
Total	**$3,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,210
- **Patient pays** $3,190

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$1,050
Coinsurance	$60
Limits or exclusions	$80
Total	**$3,190**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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