
 **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 1-888-560-4087. 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 ? | \$6,650 Individual or \$13,300 /family Combined Medical and Pharmacy Deductible | 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 , Primary Care, Specialty Care, Dialysis, Family Planning, Pediatric Vision, MH/SA Services, Hospice, Formulary Generic Drugs and Formulary Preventive Prescription Drugs 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? | No. | <u>You don't have to meet deductibles for specific services..</u> |
| What is the out-of-pocket limit for this plan ? | For network providers \$7,350 individual / \$14,700 family; for out-of-network providers there is no coverage unless Prior Authorized by Molina Healthcare. | 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 1-888-560-4087 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 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 |
|---|---|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | \$35 copay /office visit | Not covered | None |
| | Specialist visit | \$75 copay /visit | 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) | 40% coinsurance /test for blood work 40% coinsurance /test for x-rays | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 40% 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 http://MolinaMarketplace.com/MIFormulary2018.com | Generic drugs (Tier 1) | \$35 copay /prescription (retail & mail order) | Not Covered | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Please note, cost sharing reduction for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer will not apply toward any Deductible, or the Annual Out-of-Pocket maximum under Your Plan. |
| | Preferred brand drugs (Tier 2) | 35% coinsurance /prescription (retail & mail order) | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | 40% coinsurance | Not Covered | |
| | Specialty drugs (Tier 4) | 45% coinsurance | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | Not Covered | Preauthorization may be required, or services not covered. |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | Preauthorization may be required, or services not covered. |
| If you need immediate medical attention | Emergency room care | 40% coinsurance /visit | 40% coinsurance /visit | Emergency room care coinsurance does not apply, if admitted to the hospital. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Urgent care | \$75 copay /visit | Not Covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance | Not Covered | Preauthorization is required or services not covered. |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | Preauthorization may be required or services not covered. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 copay /office visit | Not Covered | Preauthorization is required for inpatient care or services not covered. |
| | Inpatient services | 40% coinsurance | Not Covered | |
| If you are pregnant | Office visits | No Charge | Not Covered | Cost sharing does not apply to routine prenatal and post-natal care 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). |
| | Childbirth/delivery professional services | 40% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 40% coinsurance | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | 20 visits/ calendar year |
| | Rehabilitation services | 40% coinsurance | Not Covered | 30 visits/ calendar year Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year). Speech Therapy (limited to 30 visits per calendar year). Cardiac Rehabilitation and Pulmonary Rehabilitation (combined benefit limit of 30 visits per calendar year). Breast Cancer Rehabilitation. Preauthorization may be required or services not covered. |
| | Habilitation services | 40% coinsurance | Not Covered | 30 visits/ calendar year Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year). Speech Therapy (Limit of 30 visits per calendar year). Preauthorization may be required or services not covered. |
| | Skilled nursing care | 40% coinsurance | Not Covered | 45 visits/calendar year. Preauthorization may be required or services not covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Durable medical equipment | 40% coinsurance | Not Covered | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required or services not covered. |
| | Hospice services | No Charge | Not Covered | 45 visits/calendar year |
| 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 standard frames and prescription lenses/year. Limited to one pair of Contact Lenses per 12 months, in lieu of Rx glasses as Medically Necessary for specified medical conditions. Low Vision Optical Devices and Services. Subject to limitations, and Prior Auth applies. |
| | Children's dental check-up | Not covered | Not covered | None |

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 when the life of the mother is endangered)
- Acupuncture
- Cosmetic Surgery (unless medically necessary)
- 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care (up to 30 visits per year if associated to Habilitation and Rehabilitation services)
- Weight Loss Programs

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: Michigan Department of Insurance and Financial Services 1-877-999-6442. 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 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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](#).

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_____ *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 | \$6,650 |
| ■ Specialist copayment | \$35 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$2,400 |
| Copayments | \$0 |
| Coinsurance | \$5,000 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,500 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,650 |
| ■ Specialist copayment | \$35 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$3,500 |
| Copayments | \$900 |
| Coinsurance | \$2,000 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$6,500 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$6,650 |
| ■ Specialist copayment | \$35 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles* | \$600 |
| Copayments | \$400 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,500 |

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.