
 **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](http://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](http://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 <a href="#">deductible</a> ?	\$0 Individual or \$0 /family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , Family Planning, Pediatric Vision, Hospice, Home Infusion (Admin only), Home Healthcare services, Dietician Services, Health Education Programs and Formulary Preventive Prescription Drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$1,250 individual / \$2,500 family; for <a href="#">out-of-network providers</a> there is no coverage unless Prior Authorized by Molina Healthcare.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See MolinaMarketplace.com or call 1-888-560-4087 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$0 <a href="#">copay</a> /office visit	Not covered	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 <a href="#">copay</a> /test for blood work \$10 <a href="#">copay</a> /test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://MolinaMarketplace.com/MIFormulary2018.com">http://MolinaMarketplace.com/MIFormulary2018.com</a>	Generic drugs (Tier 1)	\$2 <a href="#">copay</a> /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)	\$15 <a href="#">copay</a> /prescription (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	20% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	20% <a href="#">coinsurance</a>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$175 <a href="#">copay</a> /visit	\$175 <a href="#">copay</a> /visit	<a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /visit	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or services not covered.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /office visit	Not Covered	<a href="#">Preauthorization</a> is required for inpatient care or services not covered.
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	<a href="#">Cost sharing</a> does not apply to routine prenatal and post-natal care and certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	20 visits/ calendar year
	<a href="#">Rehabilitation services</a>	\$10 <a href="#">copay</a> /visit	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. <a href="#">Preauthorization</a> may be required or services not covered.
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> /visit	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). <a href="#">Preauthorization</a> may be required or services not covered.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not Covered	45 visits/calendar year. <a href="#">Preauthorization</a> may be required or services not covered.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	Not Covered	Excludes vehicle modifications, home

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)	
				modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> may be required or services not covered.
	<a href="#">Hospice services</a>	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](#).)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Abortion (except when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Cosmetic Surgery (unless medically necessary)</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> </ul> |
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**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|--|
| <ul style="list-style-type: none"> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic Care (up to 30 visits per year if associated to Habilitation and Rehabilitation services)</li> </ul> | <ul style="list-style-type: none"> <li>• Weight Loss Programs</li> </ul> |
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**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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$2,300
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,700</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$1,300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,700</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$400
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

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