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?	$0 at Indian Health Care Provider (IHCP) $6,000/Individual or $12,000/Family Deductible applies to Emergency room care, outpatient facilities and inpatient settings.	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, Family Planning, Pediatric Vision, Hospice, Home Healthcare services 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?	Yes. $1,500/Individual or $3,000/family for prescription drug coverage. .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$0 at IHCP For network providers $8,150 individual / $16,300 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
		Your Cost if You use a Participating Indian Health Care Provider (IHCP)	Your Cost if You use a Participating Molina HMO Provider	Your Cost if You use a Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	$25 copay/office visit	Not covered	None
	Specialist visit	No Charge	$75 copay/visit	Not Covered	Preauthorization may be required, or services not covered.
	Preventive care/screening/ immunization	No Charge	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)	No Charge	$40 copay/test for blood work 40% coinsurance after deductible/test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	40% coinsurance after deductible	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/MIFormulary2020.com	Tier 1 – Preferred Generic Drugs	No Charge	$15 copay/prescription	Not Covered	Preauthorization may be required, or services not covered. Mail-order Prescription Drugs are available at a 90-day supply and is offered at two times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance. For brand name drugs with a generic equivalent, coupons or
	Tier 2 – Preferred Brand Drugs	No Charge	$60 copay/prescription	Not Covered	
	Tier 3 – Non-Preferred Brand and Generic Drugs	No Charge	40% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You use a Participating Indian Health Care Provider (IHCP)	Your Cost if You use a Participating Molina HMO Provider	Your Cost if You use a Non-Participating Provider	
					any other form of third-party prescription drug cost sharing assistance will not apply toward any deductibles or annual out-of-pocket limits.
	Tier 4 – Brand and Generic Specialty Drugs	No Charge	40% coinsurance after deductible	Not Covered	Preauthorization is required, or services not covered. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	No Charge	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	No Charge	40% coinsurance after deductible	40% coinsurance after deductible	Emergency room care copay does not apply, if admitted to the hospital.
	Emergency medical transportation	No Charge	40% coinsurance	40% coinsurance	
	Urgent care	No Charge	$25 copay/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	40% coinsurance after deductible	Not Covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	No Charge	40% coinsurance after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	$25 copay/office visit	Not Covered	Preauthorization is required for inpatient care or services not covered.
	Inpatient services	No Charge	40% coinsurance after deductible	Not Covered	
If you are pregnant	Office visits	No Charge	No Charge	Not Covered	Cost sharing does not apply to routine prenatal care and first post-natal visit and certain
	Childbirth/delivery professional services	No Charge	40% coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You use a Participating Indian Health Care Provider (IHCP)	Your Cost if You use a Participating Molina HMO Provider	Your Cost if You use a Non-Participating Provider	
	Childbirth/delivery facility services	No Charge	40% coinsurance after deductible	Not Covered	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).
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Not Covered	60 visits/year. Services must be provided by an in network Home health agency.
	Rehabilitation services	No Charge	40% coinsurance after deductible/visit	Not Covered	20 combined visits/year - Physical, Occupational Therapy 20 visits/year – Speech Therapy Coinsurance amount reflects outpatient services only
	Habilitation services	No Charge	40% coinsurance after deductible/visit	Not Covered	Coinsurance amount reflects outpatient services only
	Skilled nursing care	No Charge	40% coinsurance after deductible	Not Covered	30 days/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	No Charge	40% coinsurance	Not Covered	None
	Hospice services	No Charge	No Charge	Not Covered	Preauthorization is not required. Please notify Molina before services are rendered.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	No Charge	No Charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not Covered	Not Covered	Not covered	Not Applicable. Coverage can be purchased as a standalone

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost if You use a Participating Indian Health Care Provider (IHCP)	Your Cost if You use a Participating Molina HMO Provider	Your Cost if You use a Non-Participating Provider	
					product; it is not covered by this 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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Acupuncture
- Dental Care (Child)
- Infertility treatment
- Non-emergency care when traveling outside the U.S
- Long-Term Care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Pregnancy termination
- Chiropractic Care
- Hearing Aids

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: Michigan Department of Insurance and Financial Services 1-877-999-6442.

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.

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** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$60**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher

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