
 **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 1-888-858-3973. 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](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	See the Common Medical Events chart below for your costs for services under this <a href="#">plan</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply.
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> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See MolinaMarketplace.com or call 1-888-858-3973 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Not covered	None
	<a href="#">Specialist</a> visit	\$0 <a href="#">copay</a> /visit	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 <a href="#">copay</a> /test for blood work 0% <a href="#">coinsurance</a> /test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MolinaMarketplace.com/UTFormulary2019</a>	Tier-1: Preferred Generic Drugs	\$0 <a href="#">copay</a> /prescription (retail)	Not Covered	<a href="#">Preauthorization</a> may be required, or services may be not covered. Up to 30-day supply retail. For tiers 1, 2 and 3, up to 90-day supply by mail order offered at two times the 30-day retail <a href="#">cost-sharing</a> . Coupons or any other form of third-party prescription drug <a href="#">cost-sharing</a> assistance will not apply toward any <a href="#">deductibles</a> or annual <a href="#">out-of-pocket limit</a> .
	Tier-2: Preferred Brand Drugs	\$0 <a href="#">copay</a> /prescription (retail)	Not Covered	
	Tier-3: Non-Preferred Brand and Generic Drugs	0% <a href="#">coinsurance</a> (retail)	Not Covered	
	Tier-4: Brand and Generic <a href="#">Specialty Drugs</a>	0% <a href="#">coinsurance</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	<a href="#">Cost-sharing</a> for <a href="#">emergency room care</a> does not apply if admitted to the hospital. <a href="#">Preauthorization</a> is required for out-of-area <a href="#">urgent care</a> services, or services not covered..
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$0 <a href="#">copay</a> /visit	Not Covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or services not covered.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge	Not Covered	<a href="#">Preauthorization</a> is required for inpatient care or services not covered.
	Inpatient services	0% <a href="#">coinsurance</a>	Not Covered	
<b>If you are pregnant</b>	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). Pregnancy termination services, subject to restrictions and state law
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	Not Covered	Limited to: <ul style="list-style-type: none"> <li>• Up to 2 hours nursing per visit</li> <li>• Up to 4 hours home health aide per visit</li> <li>• 30 visits per calendar year</li> </ul> <a href="#">Preauthorization</a> is required after 7 visits for home settings, or services may be not covered.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance/visit</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services may be not covered.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance/visit</a>	Not Covered	None
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	Not Covered	Limited to 30 days per calendar year. <a href="#">Preauthorization</a> may be required, or services may be not covered.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services may be not covered.
	<a href="#">Hospice services</a>	No Charge	Not Covered	Limited to 6 months in a 3-year period. Notification only, <a href="#">Preauthorization</a> is not required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not covered	One screening/exam per calendar year
	Children's glasses	No Charge	Not covered	Coverage limited to one pair of glasses (lenses and frames) or contact lenses in lieu of prescription glasses/year. Laser corrective surgery 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)	
	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 in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental Check-up (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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

- Chiropractic care
- Infertility treatment
- Routine foot care
- 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: Office of the Superintendent of Insurance 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](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: Office of the Superintendent of Insurance 1-801-538-3077.

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</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>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

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

Cost Sharing	
Deductibles*	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$60</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>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

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

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