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 1-888-858-3973. 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,000 Individual or $12,000/Family Deductible applies to 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Deductible applies to Tier 3 & 4 only.
What is the out-of-pocket limit for this plan?	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 1-888-858-3973 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.

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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	$25 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 copay/test for blood work 40% coinsurance after deductible /test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	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 **MolinaMarketplace.com /UTFormulary2020**	Tier-1: Lower-cost generic and brand name drugs	$15 copay/prescription (retail)	Not Covered	Preauthorization 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 cost-sharing. Coupons or any other form of third-party prescription drug cost-sharing assistance will not apply toward any deductibles or annual out-of-pocket limit.
	Tier-2: Preferred generic and brand name drugs	$60 copay/prescription (retail)	Not Covered	
	Tier-3: Non-preferred brand name drugs	40% coinsurance after deductible (retail)	Not Covered	
	Tier-4: Generic and brand name specialty drugs	40% coinsurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	40% coinsurance after deductible	Cost-sharing for emergency room care does not apply if admitted to the hospital. Preauthorization is required for out-of-area urgent care services, or services not covered.
	Emergency medical transportation	40% coinsurance	40% coinsurance	
	Urgent care	$25 copay/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible	Not Covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	40% coinsurance after	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)	
		deductible		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit	Not Covered	Preauthorization is required for inpatient care or services not covered.
	Inpatient services	40% coinsurance after deductible	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). Pregnancy termination services, subject to restrictions and state law
	Childbirth/delivery professional services	40% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	40% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to: • Up to 2 hours nursing per visit • Up to 4 hours home health aide per visit • 30 visits per calendar year Preauthorization is required after 7 visits for home settings, or services may be not covered.
	Rehabilitation services	40% coinsurance after deductible/visit	Not Covered	Preauthorization may be required, or services may be not covered.
	Habilitation services	40% coinsurance after deductible/visit	Not Covered	None
	Skilled nursing care	40% coinsurance after deductible	Not Covered	Limited to 30 days per calendar year. Preauthorization may be required, or services may be not covered.
	Durable medical equipment	40% coinsurance	Not Covered	Preauthorization may be required, or services may be not covered.
	Hospice services	No Charge	Not Covered	Limited to 6 months in a 3-year period. Notification only, Preauthorization is not required.
If your child needs dental or eye care	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 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 plan's overall deductible	$6000
Specialist copayment	$75
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$300
Coinsurance	$4,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,900**

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

The plan's overall deductible	$6000
Specialist copayment	$75
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*	$0
Copayments	$1,700
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	$6000
Specialist copayment	$75
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*	$500
Copayments	$200
Coinsurance	$700
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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