This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.molinahealthcare.com or by calling 1-888-296-7677.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual **$450** Family of 2 or more **$900** Applies only to Outpatient Hospital/Facility and Inpatient Hospital/Facility Services	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,250** Individual, per year **$4,500** Family, per year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and non-covered care	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.molinahealthcare.com, or call 1-888-296-7677.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on pages 6. See your policy or plan document for additional information about **excluded services.**

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Copay/visit	Not Covered	----------none----------
	Specialist visit	$30 Copay/visit	Not Covered	
	Other practitioner office visit	$10 Copay/visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test x-ray, blood work	$30 Copay/x-ray $10 Copay/blood work	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not Covered	Prior authorization is required, or services may be not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.molinahealthcare.com	Tier 1 - Generic drugs	$5 Copay (retail)	Not Covered	Prior authorization may be required, or services may be not covered. Up to 30-day supply retail. Up to 90-day supply mail order offered at two times the 30-day retail Cost Sharing.
	Tier 2 - Preferred brand drugs	$30 Copay (retail)	Not Covered	
	Tier 3 - Non-preferred brand drugs	20% Coinsurance (retail)	Not Covered	
	Tier 4 - Specialty drugs	20% Coinsurance	Not Covered	Prior authorization is required, or services may be not covered. Maximum cost sharing of $100 for a 30-day supply of oral chemotherapy drugs.
	Tier 5 - Preventive drugs	No Charge	Not Covered	Prior authorization may be required, or services may be not covered. Up to 30-day supply retail. Up to 90-day supply mail order.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	Prior authorization may be required, or services may be not covered.
	Physician/surgeon fees	20% Coinsurance	Not Covered	
If you need immediate medical attention	Emergency room services	$150 Copay/visit	$150 Copay/visit	Does not apply, if admitted to the hospital
	Emergency medical transportation	$150 Copay/trip	$150 Copay/trip	----------none----------
	Urgent care	$30 Copay/visit	$30 Copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	Prior authorization may be required, or services may be not covered.
	Physician/surgeon fee	20% Coinsurance	Not Covered	
You have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copay/visit	Not Covered	Prior authorization may be required, or services may be not covered.
	Mental/Behavioral health inpatient services	20% Coinsurance	Not Covered	Prior authorization is required, or services may be not covered.
	Substance use disorder outpatient services	$10 Copay/visit	Not Covered	Prior authorization may be required, or services may be not covered.
	Substance use disorder inpatient services	20% Coinsurance	Not Covered	Prior authorization is required or services may be not covered.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	----------none----------
	Delivery and all inpatient services	20% Coinsurance	Not Covered	For delivery, notification only is required, and prior authorization is not required. Pregnancy termination services are subject to restrictions and state law, and prior authorization may be required, or services may be not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to up to two (2) hours nursing per visit and up to four (4) hours home health aide per visit. Limit is 100 visits per calendar year for all home health visits except private duty nursing. Private duty nursing visits are limited to 90 visits per calendar year. Prior authorization may be required, or services may be not covered.
	Rehabilitation services	20% Coinsurance	Not Covered	Limited to: • 20 visits/year per therapy - Physical, Speech, Occupational, Pulmonary Therapy • 36 visits/year - Cardiac rehabilitation • 12 visits/year – Manipulation Therapy Prior authorization may be required, or services may be not covered.
	Habilitation services	20% Coinsurance	Not Covered	Prior authorization may be required, or services may be not covered.
	Skilled nursing care	20% Coinsurance	Not Covered	Limited to 90 days per calendar year. Prior authorization is required, or services may be not covered.
	Durable medical equipment	20% Coinsurance	Not Covered	Prior authorization may be required, or services may be not covered.
	Hospice service	No Charge	Not Covered	Notification only; prior authorization is not required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	One screening/exam per calendar year
	Glasses	No Charge	Not Covered	Limited to: • One pair of standard frames and prescription lenses every 12 months • One pair of standard contact lenses every 12 months, in lieu of prescription glasses • Low vision optical devices, evaluation every 5 years Laser corrective surgery is not covered.
	Dental check-up	Not Covered	Not Covered	Not Applicable

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- 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.
- Routine foot care

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-296-7677. You may also contact your state insurance department at the Ohio Department of Insurance 1-800-686-1526.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-888-296-7677.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-888-296-7677.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,870
- **Patient pays** $1,670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$450
Copays	$180
Coinsurance	$890
Limits or exclusions	$150
Total	**$1,670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,340
- **Patient pays** $1,060

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$450
Copays	$320
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,060**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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