




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 1-833-657-1981. 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?	Individual: \$0 Family: \$0	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	There is no deductible for this plan	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual: \$0 Family: \$0	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See MolinaMarketplace.com or call 1-888-858-3973 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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
		Network Provider (You will pay the least)	Out-of-Network 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	\$0	\$0	None
	<u>Specialist</u> visit	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0	\$0	None
	Imaging (CT/PET scans, MRIs)	\$0	\$0	<u>Preauthorization</u> is required or Imaging services are not covered
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.molinamarketplace.com	Generic drugs	\$0	\$0	<u>Preauthorization</u> 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 <u>cost-sharing</u> . For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug <u>cost-sharing</u> assistance will not apply toward any <u>deductibles</u> or annual out-of-pocket limit.
	Preferred brand drugs	\$0	\$0	
	Non-preferred brand drugs	\$0	\$0	
	<u>Specialty drugs</u>	\$0	\$0	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
	Physician/surgeon fees	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
If you need immediate medical attention	<u>Emergency room care</u>	\$0	\$0	<u>Cost-sharing</u> for emergency room care does not apply if admitted to the hospital.
	<u>Emergency medical transportation</u>	\$0	\$0	None.
	<u>Urgent care</u>	\$0	\$0	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
	Physician/surgeon fees	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0	None
	Inpatient services	\$0	\$0	<u>Preauthorization</u> is required for inpatient care or services not covered.
If you are pregnant	Office visits	No charge	No charge	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>cost sharing</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$0	\$0	
	Childbirth/delivery facility services	\$0	\$0	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	Services must be provided by a home health agency. <u>Preauthorization</u> may be required, or services may be not covered.
	<u>Rehabilitation services</u>	\$0	\$0	20 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	<u>Habilitation services</u>	\$0	\$0	<u>Preauthorization</u> may be required, or services not covered.
	<u>Skilled nursing care</u>	\$0	\$0	30 visits/calendar year
	<u>Durable medical equipment</u>	\$0	\$0	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage limited to one exam/year.
	Children's glasses	No charge	No charge	Coverage limited to one pair of glasses (lenses and frames) or contact lenses in lieu of prescription glasses/year. Laser corrective surgery not covered.
	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.)

- Infertility Treatment
- Bariatric Surgery
- Cosmetic Surgery
- Treatment for Temporomandibular Joint Disorders
- Long Term/Custodial Nursing Home Care
- Hearing Aids
- Acupuncture
- Abortion (except in cases of rape, incest or to save the life of the mother)
- Private Duty Nursing
- Routine Foot Care Not Related to Diabetes Care
- Weight Loss Programs
- Routine Adult Vision

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

- Chiropractic Care
- Allergy Testing

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: Idaho Department of Insurance at 1-800-721-3272 or at doi.idaho.gov. 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 on how 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: Molina Customer Service at 1-833-657-1981 or the Idaho Department of Insurance at 1-800-721-3272.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-657-1981

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) Copayment	\$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
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In this example, Peg would pay:

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

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) Copayment	\$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	\$5,600
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In this example, Joe would pay:

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

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$0
■ Hospital (facility) Copayment	\$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	\$2,800
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In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.