



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, www.mollihealth.com.

For general definitions of common terms, such as allowed amount, balance billing, Coinsurance, Co-Payment, Deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.mollihealth.com.

Important Questions	Answers	Why This Matters:
What is the overall <u>Deductible</u>?	<u>Network</u> : \$5,000 /Individual or \$10,000 /Family per Calendar Year <u>Non-Network</u> : \$15,000 / Individual or \$30,000 /Family per Calendar Year	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 policy, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> has been met.
Are there services covered before you meet your <u>Deductible</u>?	Yes. Preventive care services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>Deductible</u> amount. For example, this <u>plan</u> covers certain <u>preventive</u> services before you meet your <u>Deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>Deductibles</u> for specific services?	No.	You don't have to meet <u>Deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$5,000 /Individual or \$10,000 /Family per Calendar Year <u>Non-Network</u> : \$15,000 /Individual or \$30,000 /Family per Calendar Year	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 individual <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Ineligible charges, amounts over the <u>maximum allowable charge</u> , <u>premiums</u> , <u>balanced-billing</u> charges penalties, 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>Network provider</u>?	Yes , see the back of your ID card for more information.	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 a <u>Non-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 (a <u>balance bill</u>). Be aware, your <u>Network provider</u> might use a <u>Non-Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No , you do not need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **Co-Payment** 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
		<u>Network Provider</u>	<u>Non-Network Provider</u>	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	After Deductible, plan pays 100%	After Deductible, plan pays 100%	Telemedicine (Virtual Primary Care) is free through Vitable.
	<u>Specialist</u> visit	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
	<u>Preventive care/screening/Immunization</u>	No Charge	After Deductible, plan pays 100%	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
	Imaging (CT/PET scans, MRIs)	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
If you need drugs to treat your illness or condition See your ID card for more information about <u>prescription drug coverage</u> .	Generic Drugs	30-day: <u>After Deductible plan pays 100%</u> 90-day retail: <u>After Deductible plan pays 100%</u> 90-day Mail Order: <u>After Deductible plan pays 100%</u>		Covers up to a 30-day or 90-day supply (Retail) and Covers up to a 90-day supply (Mail Order) No <u>Co-Payment</u> for generic prescriptions mandated by the Affordable Care Act (ACA), including, but not limited to, tobacco cessation medications and generic women's contraceptives.
	Formulary Brand Drugs	30-day: <u>After Deductible plan pays 100%</u> 90-day Mail Order: <u>After Deductible plan pays 100%</u>		
	Non-Formulary Brand Drugs	30-day: <u>After Deductible plan pays 100%</u> 90-day Mail Order: <u>After Deductible plan pays 100%</u>		
	<u>Specialty Drugs</u>	Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____

* For more information about limitations and exceptions, see the plan or policy document in your member portal at www.mollihealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Non-Network Provider</u>	
	Physician/surgeon fees	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	After Deductible, plan pays 100%	Paid at <u>Network</u> level	<u>Co-Payment</u> waived if admitted.
	<u>Emergency medical transportation</u>	After Deductible, plan pays 100%	Paid at <u>Network</u> level	<u>Out-of-Network</u> benefits are limited to \$15,000 per trip.
	<u>Urgent care</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
	Physician/surgeon fees	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
	Inpatient services	After Deductible, plan pays 100%	After Deductible, plan pays 100%	_____none_____
If you are pregnant	Office visits	After Deductible, plan pays 100%	After Deductible, plan pays 100%	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	After Deductible, plan pays 100%	After Deductible, plan pays 100%	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Non-Network Provider</u>	
	Childbirth/delivery facility services	After Deductible, plan pays 100%	After Deductible, plan pays 100%	
If you need help recovering or have other special health needs	<u>Home health care</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	Limited to 40 visits per Calendar Year combined with Private Duty Nursing.
	<u>Rehabilitation services</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	Cognitive Rehabilitation Outpatient, Occupational Therapy, Physical Therapy, Speech Therapy, Chiropractic, and Post-Cochlear Implant Aural Therapy are subject to deductible. Limited to 40 visits per Calendar Year for each service type.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	—————none—————
	<u>Durable medical equipment (DME)</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	—————none—————
	<u>Hospice services</u>	After Deductible, plan pays 100%	After Deductible, plan pays 100%	Includes Bereavement and Respite care. One benefit period not to exceed 6-months.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to 1 per Calendar Year.
	Children's glasses	Not Covered	Not Covered	—————none—————
	Children's dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Dental care (adult)• Glasses (child)• Routine foot care (unless medically necessary)	<ul style="list-style-type: none">• Bariatric surgery• Dental care (pediatric)• Infertility treatment• Weight loss programs	<ul style="list-style-type: none">• Cosmetic surgery• Dental Check-up• Long-term care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Chiropractic care• Private-duty nursing	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Hearing aids (Limited to 1 item per ear every 36 months. Newborn Hearing aids no limit)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-245-0533.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-245-0533.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 800-245-0533 uff.

—————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, Co-Payments 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 Network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	0%
■ Other [<u>cost sharing</u>]	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:

Cost Sharing	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$5,000

Managing Joe's type 2 Diabetes

(a year of routine Network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	0%
■ Other [<u>cost sharing</u>]	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:

Cost Sharing	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$5,000

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	0%
■ Other [<u>cost sharing</u>]	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:

Cost Sharing	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800