MOLINA HEALTHCARE

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	Silver 1					
	Cost					
	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1		
VALUE BASICS						
Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free		
Annual Wellness Visit - Adults	Free	Free	Free	Free		
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free		
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free		
Preventive Prescription Drugs	Free	Free	Free	Free		
24-Hour Nurse Advice Line	Free	Free	Free	Free		
Plan Options with Adult Vision Services	Yes	Yes	Yes	Yes		
BENEFITS AND COST SHARE HIGHLIGHTS						
Deductible (Ind/Fam)	\$0 / \$0	\$850 / \$1,700	\$3,500 / \$7,000	\$5,750 / \$11,500		
Drug Deductible (Ind/Fam)	\$0 / \$0	Comb. w/Med	Comb. w/Med	Comb. w/Med		
Out of Pocket Max (Ind/Fam)	\$2,700 / \$5,400	\$2,825 / \$5,650	\$6,775 / \$13,550	\$7,940 / \$15,880		
Emergency Room Facility	15%	30% after ded	40% after ded	40% after ded		
Urgent Care Services	\$5	\$25	\$55	\$55		

SERVICES WITHOUT ANY DEDUCTIBLE

<sup>\*\*</sup> Denotes no charge for the first 4 non-preventive office visits for any combination of the indicated visit types. Mail-order is available for non-specialty drugs marked MAIL" on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount.



	Silver 1					
	Cost					
	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1		
INPATIENT SERVICES						
Inpatient Facility Fee *Professional Fees May Apply	15%	30% after ded	40% after ded	40% after ded		
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	\$0	\$8	\$30	\$35		
Specialty Care	\$10	\$30	\$60	\$60		
Rehabilitative and Habilitative Services	\$10	\$30	\$30	\$35		
Mental / Behavioral Health Services / Substance Use Disorder Services	\$0	\$8	\$30	\$35		
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	15%	30% after ded	40% after ded	40% after ded		
Outpatient Professional Fee	15%	30% after ded	40% after ded	40% after ded		
Advanced Imaging and Specialized Scanning Services	15%	30% after ded	40% after ded	40% after ded		
Routine X-Ray and Diagnostic Services	\$30	\$75	\$95	\$95		
Laboratory Tests	\$10	\$30	\$60	\$75		

SERVICES WITHOUT ANY DEDUCTIBLE

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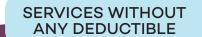
	Silver 1					
	Cost					
	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1		
PRESCRIPTION DRUGS <sup>§</sup>						
Preventive Drugs	No Charge	No Charge	No Charge	No Charge		
Preferred Generic Drugs	\$0	\$5	\$15	\$20		
Preferred Brand Drugs	\$30	\$65	\$75 after ded	\$75 after ded		
Non-Preferred Drugs	15%	30% after ded	40% after ded	40% after ded		
Specialty Drugs	15%	30% after ded	40% after ded	40% after ded		



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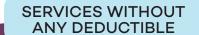
	Silver 12 with First 4 Primary Care Visits Free				
	Cost Sharing Reduction Plans (CSR)				
	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12	Gold 1
VALUE BASICS					
Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free	Free
Annual Wellness Visit - Adults	Free	Free	Free	Free	Free
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free	Free
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free	Free
Preventive Prescription Drugs	Free	Free	Free	Free	Free
24-Hour Nurse Advice Line	Free	Free	Free	Free	Free
Plan Options with Adult Vision Services	No	No	No	No	Yes
BENEFITS AND COST SHARE HIGHLIGHTS					
Deductible (Ind/Fam)	\$150 / \$300	\$1,425 / \$2,850	\$6,500 / \$13,000	\$7,000 / \$14,000	\$1,640 / \$3,280
Drug Deductible (Ind/Fam)	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med	Comb. w/Med
Out of Pocket Max (Ind/Fam)	\$3,050 / \$6,100	\$3,050 / \$6,100	\$7,350 / \$14,700	\$9,200 / \$18,400	\$8,100 / \$16,200
Emergency Room Facility	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded
Urgent Care Services	\$3	\$13	\$55	\$60	\$20



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	Silver 12 with First 4 Primary Care Visits Free					
	Cost Sharing Reduction Plans (CSR)					
	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12	Gold 1	
INPATIENT SERVICES						
Inpatient Facility Fee *Professional Fees May Apply	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVI	CES					
Primary Care	\$2**	\$10**	\$35**	\$40**	\$20	
Specialty Care	\$4	\$15	\$60	\$62.50	\$50	
Rehabilitative and Habilitative Services	10% after ded	20% after ded	20% after ded	20% after ded	\$20	
Mental / Behavioral Health Services / Substance Use Disorder Services	\$2**	\$10**	\$35**	\$40**	\$20	
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	
Outpatient Professional Fee	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	
Advanced Imaging and Specialized Scanning Services	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	
Routine X-Ray and Diagnostic Services	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	
Laboratory Tests	10% after ded	20% after ded	20% after ded	20% after ded	\$15	



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		Silver 12 with First 4 Primary Care Visits Free			
	Cost S	haring Reduction Plan			
	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12	Gold 1
PRESCRIPTION DRUGS <sup>§</sup>					
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	\$2	\$5	\$5	\$5	\$15
Preferred Brand Drugs	\$20	\$50	\$100	\$100	\$50 after ded
Non-Preferred Drugs	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded
Specialty Drugs	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded



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