Molina Marketplace Silver 200 Plan – Ohio
2018 Benefit Plan Changes

Standard Plan ID – 64353OH001000204

Changes to Your Plan	2017		2018	
Deductible				
Individual / Family Medical Deductible	$2,275 / $4,550		$2,500 / $ 5,000	
Individual / Family Pharmacy Deductible	No Rx deductible		$400 / $800	
Annual Out-of-Pocket Maximum				
Individual / Family Out-of-Pocket Maximum	$5,700 / $11,400		$5,850 / $11,700	
Emergency/Urgent Services				
Emergency Room	$400	Copayment	$400	Copayment after deductible
Outpatient Professional Services				
Specialty Care Office Visits	$55	Copayment	$60	Copayment
Dental Services Related to Accidental Injury	30%	Coinsurance	40%	Coinsurance
Vision Services Related to Accidental Injury or Diseases of the Eye	30%	Coinsurance	40%	Coinsurance
Habilitative/Rehabilitative Services	30%	Coinsurance	$60	Copayment
Outpatient Hospital / Facility Services				
Outpatient Surgical & Non-Surgical Services (Professional & Facility Services)	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Specialized Scanning (MRI, CT, PET)	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Infertility Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Mental / Behavioral Health Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Substance Abuse Disorder Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Radiology Services (e.g., X-Rays)	$55	Copayment	$65	Copayment
Laboratory Tests	$35	Copayment	$40	Copayment
Inpatient Hospital Services				
Medical/Surgical Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Maternity	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Mental/Behavioral Health Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Substance Abuse Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Infertility Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Skilled Nursing Facility	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Prescription Drug Coverage				
Formulary Preferred Brand Name Drugs	$55	Copayment	$60	Copayment
Formulary Non-Preferred Brand Name Drugs	40%	Coinsurance	50%	Coinsurance after deductible
Formulary Specialty (Oral and Injectable) Drugs	40%	Coinsurance	50%	Coinsurance after deductible
Ancillary Services				
Emergency Medical Transportation (Ambulance)	30%	Coinsurance	40%	Coinsurance
Durable Medical Equipment	30%	Coinsurance	40%	Coinsurance
Other Services				
Dialysis Services	$55	Copayment	$60	Copayment