Molina Marketplace Silver 250 Plan - Ohio
2018 Benefit Plan Changes

Standard Plan ID – 64353OH001000201
Limited Cost Share (LCS)* Plan ID -64353OH001000203

Changes to Your Plan	2017		2018	
Deductible				
Individual / Family Medical Deductible	$2,400 / $4,800		$4,950 / $ 9,900	
Individual / Family Pharmacy Deductible	No Rx deductible		$400 / $800	
Annual Out-of-Pocket Maximum				
Individual / Family Out-of-Pocket Maximum	$7,150 / $14,300		$7,350 / $14,700	
Emergency/Urgent Services				
Emergency Room	$400	Copayment	$400	Copayment after deductible
Outpatient Professional Services				
Primary Care Office Visits	$20	Copayment	$30	Copayment
Specialty Care Office Visits	$55	Copayment	$75	Copayment
Other Practitioner Care Office Visits	$20	Copayment	$30	Copayment
Dental Services Related to Accidental Injury	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Vision Services Related to Accidental Injury or Diseases of the Eye	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Mental/Behavioral Health or Substance Abuse Disorder Services Office Visit	$20	Copayment	$30	Copayment
Habilitative/Rehabilitative Services	30%	Coinsurance	$75	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
Radiation Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Mental / Behavioral Health Services or Substance Abuse Disorder Services	30%	Coinsurance after deductible	40%	Coinsurance after deductible
Radiology Services (e.g., X-Rays)	$55	Copayment	$75	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 or 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 Generic Drugs	$10	Copayment	$20	Copayment
Formulary Preferred Brand Name Drugs	$55	Copayment	$60	Copayment

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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	$75	Copayment

*LCS Plan - If you are a qualifying American Indian or Alaskan Native, you will have no cost sharing if you obtain covered services from any participating Tribal Health Provider. However, you will be responsible for cost sharing under this product for any covered services not provided by a Participating Tribal Health Provider. Tribal Health Providers include the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.