2025

Molina Marketplace Benefits At A Glance - Ohio

Affordable, quality health coverage for all. Learn more at ChooseMolina.com

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MOLINA® HEALTHCARE

				Silver 1				Silver 8			
				Cost Sharing Reduction Plans (CSR)				Cost Sharing Reduction Plans (CSR)			
	Bronze 8	Bronze 9	Bronze 10	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250
VALUE BASICS											
Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Annual Wellness Visit - Adults	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Preventive Prescription Drugs	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
24-Hour Nurse Advice Line	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free
Plan Options with Adult Vision Services	No	No	No	Yes	Yes	Yes	Yes	No	No	No	No
BENEFITS AND COST SHARE HIGHLIGHTS											
Deductible (Ind/Fam)	$7,500 / $15,000	$5,950 / $11,900	$2,850 / $5,700	$0 / $0	$850 / $1,700	$3,500 / $7,000	$5,750 / $11,500	$0 / $0	$500 / $1,000	$3,000 / $6,000	$5,000 / $10,000
Drug Deductible (Ind/Fam)	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	$0 / $0	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med	$0 / $0	Comb. w/ Med	Comb. w/ Med	Comb. w/ Med
Out of Pocket Max (Ind/Fam)	$9,200 / $18,400	$7,950 / $15,900	$9,200 / $18,400	$2,700 / $5,400	$2,825 / $5,650	$6,775 / $13,550	$7,940 / $15,880	$2,000 / $4,000	$3,000 / $6,000	$6,400 / $12,800	$8,000 / $16,000
Emergency Room Facility	50% after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	25%	30% after ded	40% after ded	40% after ded
Urgent Care Services	$75	$100	$100	$5	$25	$55	$55	$5	$30	$60	$60

** 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.

SERVICES WITHOUT ANY DEDUCTIBLE

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	Bronze 8	Bronze 9	Bronze 10	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250
INPATIENT SERVICES											
Inpatient Facility Fee **Professional Fees May Apply*	50% after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	25%	30% after ded	40% after ded	40% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES											
Primary Care	$50	$50	$50	$0	$8	$30	$35	$0	$20	$40	$40
Specialty Care	$100	$100 after ded	$100 after ded	$10	$30	$60	$60	$10	$40	$80	$80
Rehabilitative and Habilitative Services	$50	50% after ded	50% after ded	$10	$30	$30	$35	$0	$20	$40	$40
Mental / Behavioral Health Services / Substance Use Disorder Services	$50	$50	$50	$0	$8	$30	$35	$0	$20	$40	$40
OUTPATIENT HOSPITAL FACILITY SERVICES											
Outpatient Facility Fee	50% after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	25%	30% after ded	40% after ded	40% after ded
Outpatient Professional Fee	50% after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	25%	30% after ded	40% after ded	40% after ded
Advanced Imaging and Specialized Scanning Services	50% after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	25%	30% after ded	40% after ded	40% after ded
Routine X- Ray and Diagnostic Services	50% after ded	50% after ded	50% after ded	$30	$75	$95	$95	25%	30% after ded	40% after ded	40% after ded
Laboratory Tests	50% after ded	50% after ded	50% after ded	$10	$30	$60	$75	25%	30% after ded	40% after ded	40% after ded

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	Bronze 8	Bronze 9	Bronze 10	Silver 1 100	Silver 1 150	Silver 1 200	Silver 1 250	Silver 8 100	Silver 8 150	Silver 8 200	Silver 8 250
PRESCRIPTION DRUGS§											
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	$25	$25	$25	$0	$5	$15	$20	$0	$10	$20	$20
Preferred Brand Drugs	$50 after ded	$100 after ded	$100 after ded	$30	$65	$75 after ded	$75 after ded	$15	$20	$40	$40
Non-Preferred Drugs	$100 after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	$50	$60 after ded	$80 after ded	$80 after ded
Specialty Drugs	$500 after ded	50% after ded	50% after ded	15%	30% after ded	40% after ded	40% after ded	$150	$250 after ded	$350 after ded	$350 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 12 250	Gold 1	Gold 8
VALUE BASICS						
Teladoc Virtual Care Visits 24/7/365	Free	Free	Free	Free	Free	Free
Annual Wellness Visit - Adults	Free	Free	Free	Free	Free	Free
Routine Preventive Screenings - Children & Adults	Free	Free	Free	Free	Free	Free
Routine Vision Exams and Eyewear - Children (Ages 0-18)	Free	Free	Free	Free	Free	Free
Preventive Prescription Drugs	Free	Free	Free	Free	Free	Free
24-Hour Nurse Advice Line	Free	Free	Free	Free	Free	Free
Plan Options with Adult Vision Services	No	No	No	No	Yes	No
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	$1,500 / $3,000
Drug Deductible (Ind/Fam)	Comb. w/Med	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	$7,800 / $15,600
Emergency Room Facility	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Urgent Care Services	$3	$13	$55	$60	$20	$45

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	Silver 12 100	Silver 12 150	Silver 12 200	Silver 12 250	Gold 1	Gold 8
INPATIENT SERVICES						
Inpatient Facility Fee **Professional Fees May Apply*	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES						
Primary Care	$2**	$10**	$35**	$40**	$20	$30
Specialty Care	$4	$15	$60	$62.50	$50	$60
Rehabilitative and Habilitative Services	10% after ded	20% after ded	20% after ded	20% after ded	$20	$30
Mental / Behavioral Health Services / Substance Use Disorder Services	$2**	$10**	$35**	$40**	$20	$30
OUTPATIENT HOSPITAL FACILITY SERVICES						
Outpatient Facility Fee	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Outpatient Professional Fee	10% after ded	20% after ded	20% after ded	20% after ded	25% 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	25% after ded
Routine X- Ray and Diagnostic Services	10% after ded	20% after ded	20% after ded	20% after ded	25% after ded	25% after ded
Laboratory Tests	10% after ded	20% after ded	20% after ded	20% after ded	$15	25% after ded

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PRESCRIPTION DRUGS§						
Preventive Drugs	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Preferred Generic Drugs	$2	$5	$5	$5	$15	$15
Preferred Brand Drugs	$20	$50	$100	$100	$50 after ded	$30
Non-Preferred Drugs	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded	$60
Specialty Drugs	10% after ded	20% after ded	20% after ded	20% after ded	30% after ded	$250

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