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, <u>www.MolinaMarketplace.com</u> For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-800-318-2596 to request a copy.

Important Quantiana		Why This Matters
Important Questions What is the overall deductible? Are there services covered before you meet your deductible?	Combined Medical and Rx Yes. <u>Preventive care</u> , Family	Why This Matters: Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits</u> /.
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</u> <u>limit</u> for this <u>plan</u> ?	\$6,500 Individual or \$13,000/family	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 <u>out-of-pocket limits</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> ?	Premiums, balance-billing charges, and 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.MolinaMarketplace.com or call 1-888-858-3492 for a list of <u>participating providers</u>	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 an <u>out-of-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 (<u>balance</u> <u>billing</u>). Be aware, your <u>network Provider</u> might use an <u>out-of-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 can see the <u>specialist</u> you choose without a <u>referral</u> .

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.				
What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /office visit	Not covered	None
If you visit a health care	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	Not covered	Preauthorization may be required, or services not covered.
provider's office or clinic	Preventive care/screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$15 <u>copay</u> /test for blood work 20% <u>copayment</u> after	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>copayment</u> after <u>deductible</u> per test	Not covered	Preauthorization is required or Imaging services are not covered.
If you need drugs to	Generic drugs	\$10 <u>copay</u> /prescription <u>deductible</u> does not apply (retail); \$20 cost share for 90 day supply <u>deductible</u> does not apply (mail)	Not covered	Preauthorization may be required or services may not be covered. Mail-order <u>Prescription</u> <u>Drugs</u> are available at a 90-day supply and is offered at two times the 30-day retail prescription <u>Cost Sharing</u> . Depending on Tier
treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is	Preferred brand drugs	\$50 <u>copay</u> /prescription <u>deductible</u> does not apply (retail); \$100 cost share for 90 day supply <u>deductible</u> does not apply (mail)	Not covered	level this will be either a <u>Copayment</u> or a <u>Coinsurance</u>
available at www.molinamarketpla ce/TXFormulary2021.c om	Non-preferred brand drugs	30% <u>copayment</u> after <u>deductible</u> (retail); 2x cost share of 30% <u>copayment</u> after <u>deductible</u> for 90 day supply (mail)	Not covered	
	Specialty drugs	30% <u>copayment</u> after <u>deductible</u>	Not covered	

* For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.Molinahealthcare.com</u>

What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Facility fee (e.g., ambulatory surgery center)	20% <u>copayment</u> after <u>deductible</u> for facility per day	Not covered	Preauthorization may be required, or services not covered.
If you have outpatient surgery	Physician/surgeon fees	20% <u>copayment</u> after <u>deductible</u> per day	Not covered	Preauthorization may be required, or services not covered. Laser corrective eye surgery is not covered.
If you need immediate	Emergency room care	20% <u>copayment</u> after <u>deductible</u> per visit	20% <u>copayment</u> after deductible per visit	Emergency room care copay does not apply, if admitted to the hospital.
If you need immediate medical attention	Emergency medical transportation Urgent care	20% <u>copayment</u> after <u>deductible</u> per trip \$10 copay/visit	20% <u>copayment</u> after <u>deductible</u> per trip Not covered	None
If you have a hospital	Facility fee (e.g., hospital room)	20% <u>copayment</u> after deductible per day	Not covered	Preauthorization is required or services not covered.
stay	Physician/surgeon fees	20% <u>copayment</u> after <u>deductible</u> /visit	Not covered	None
lf you need mental health, behavioral health, or substance	Outpatient services	\$10 copay/office visit Outpatient Intensive Psychiatric Treatment Programs - 20% <u>copayment</u> after deductible per day	Not covered	Preauthorization is required for Electroconvulsive Therapy (ECT), neuropsycological and psychological testing, partial <u>hospitalization</u> , behavioral health treatment for PDD/autism, substance abuse
abuse services	Inpatient services	20% <u>copayment</u> after <u>deductible</u> per day		services, Day Treatment, detoxification services and <u>inpatient</u> care or services not covered.
	Office visits	No Charge	Not covered	Cost sharing does not apply to routine prenatal
If you are pregnant	Childbirth/delivery professional services	20% <u>copayment</u> after <u>deductible per day /visit</u>	Not covered	care and first post-natal visit and certain preventive services. Depending on the type of
n you are pregnant	Childbirth/delivery facility services	20% <u>copayment</u> after <u>deductible p</u> er day	Not covered	services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have	Home health care	No Charge		60 visits/year. Services must be provided by an in <u>network</u> Home health agency.

What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special needs	Rehabilitation services	\$50 <u>copay</u> /visit	Not covered	35 visits/year. <u>Medically necessary</u> services only. <u>Preauthorization</u> is required for Occupational Therapy, Speech Therapy, Physical Therapy, Radiation therapy and radio surgery <u>Rehabilitation services</u> or services not covered.
	Habilitation services	\$50 <u>copay</u> /visit	Not covered	35 visits/year. Does not apply to Mental / Behavioral Health Services and Substance Abuse Disorder Services conditions.
	Skilled nursing care	20% <u>copayment</u> after deductible per day	Not covered	25 days/calendar year. <u>Preauthorization</u> is required or services not covered.
	Durable medical equipment	20% <u>copayment</u> after <u>deductible p</u> er request	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <u>Preauthorization</u> may be required or services not covered
	Hospice services	No Charge	Not covered	None
	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
If your shild poods	Children's glasses	No Charge	Not covered	Coverage limited to one pair of glasses/year.
If your child needs dental or eye care	Children's dental checkups	Not Covered	Not covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

Excluded Services & Other Covered Services

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
 Abortion (except in cases of rape, incest, or when the life of the mother is endangered) 	Dental Care (Adult)Dental Care (Child)	 Non-emergency care when traveling outside the U.S 		
 Acupuncture Bariatric Surgery 	Infertility treatment	 Routine Foot Care Weight Loss Programs 		
Cosmetic Surgery	Long-Term Care			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)				
 Chiropractic Care (related to Rehabilitation benefits, combined 35 visit limit) 	Hearing Aids (1 hearing aid every 36 months)	 Private Duty Nursing (<u>Medically Necessary</u>) Routine eye care (Adult) 		

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: Molina Healthcare of Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: : Molina Healthcare of Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439.

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 1-888-560-2025. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-560-2025. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-560-2025. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne' 1-888-560-2025.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

\$0

\$50

0%

- The plan's overall deductible
- Specialist copay
- Hospital (facility) <u>copay</u> per day 20% after <u>deductible</u>
- Other <u>coinsurance</u>

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	

Cost Sharing	
Deductibles	\$2,900
<u>Copayments</u>	\$300
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,960
	[The plan w

	Managing Joe's Type 2 Dia (a year of routine in-network care of controlled condition)	
•	The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>copay</u> per day	\$0 \$50 20%
	after <u>deductible</u> Other coinsurance	0%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	

(Cost Sharing
Deductibles	\$800
Copayments	\$900
<u>Coinsurance</u>	\$300

What isn't covered	
Limits or exclusions	\$20

The total Joe would pay is

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u> \$0
 <u>Specialist copay</u> \$50
 Hospital (facility) <u>copay</u> per day after <u>deductible</u>
 Other <u>coinsurance</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
•	

In this example, Mia would pay:

Со	st Sharing
Deductibles	\$0
<u>Copayments</u>	\$100
Coinsurance	\$1,000

What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,500	
d services l		

[The plan would be responsible for the other costs of these EXAMPLE covered services.]

\$1.920