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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,300 / individual or $12,600 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, lab services, outpatient habilitation and rehabilitation services, and the first three non-preventive office visits for any combination of primary care, specialist, urgent care, mental health, or substance abuse services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $500/individual or $1000/family for prescription drug coverage. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,200 individual / $16,400 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See MolinaMarketplace.com or call 1-888-858-2150 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$65 copay/office visit; deductible applies.	Not covered	Includes non-preventive OB/GYN and pediatrician visits.
	Specialist visit	$95 copay/office visit; deductible applies.	Not covered	Preauthorization may be required, or services not covered.
	Preventive care/screening/ immunization	No charge; deductible does not apply.	Not covered	Includes most prenatal services. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance, x-ray; deductible applies. $40 copay/test, lab; deductible does not apply.	Not covered	X-ray cost sharing also applies to ultrasound services.
	Imaging (CT/PET scans, MRIs)	40% coinsurance; deductible applies.	Not covered	Preauthorization may be required, or services not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at MolinaMarketplace.com /CAformulary2022	Tier 1	$80 copay/prescription (retail); deductible applies. $160 copay/prescription (mail order); deductible applies.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Maximum cost sharing of $250 for a 30-day supply of oral chemotherapy drugs, and deductible does not apply. Maximum cost sharing of $500 for a 30-day supply of Tier 2, 3 or 4 drugs, after deductible. Preauthorization may be required, or services not covered. Cost sharing for any prescription drugs obtained through the use of a discount card or coupon provided by a prescription drug manufacturer will not apply toward any deductible or the out-of-pocket limit. Cost Sharing for covered prescription drugs is limited to be no more than the pharmacy's retail price.
	Tier 2	40% coinsurance (retail); deductible applies. 26.67% coinsurance (mail order); deductible applies.	Not covered	
	Tier 3	40% coinsurance (retail); deductible applies. 26.67% coinsurance (mail order); deductible applies.	Not covered	
	Tier 4	40% coinsurance (retail); deductible applies. Not covered (mail order).	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance; deductible applies.	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	40% coinsurance; deductible applies.	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance; deductible applies.	40% coinsurance; deductible applies.	This cost does not apply, if admitted directly to the hospital for inpatient services. (Refer to "If you have a hospital stay," for applicable costs.) Non-Participating Provider is covered only until stabilization and arrangement of transfer to a Participating Provider.
	Emergency medical transportation	40% coinsurance; deductible applies.	40% coinsurance; deductible applies.	None.
	Urgent care	$65 copay/visit; deductible applies.	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance; deductible applies.	Not covered	Preauthorization is required, or services not covered.
	Physician/surgeon fees	40% coinsurance; deductible applies.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$65 copay/office visit; deductible applies.	Not covered	Preauthorization may be required, or services not covered. Includes individual, group evaluation, counseling, intensive outpatient, day treatment programs.
	Inpatient services	40% coinsurance; deductible applies.	Not covered	Preauthorization is required, or services not covered. Deductible applies only to facility fees.
If you are pregnant	Office visits	$65 copay/visit, primary care visit; deductible applies. $95 copay/visit, specialist visit; deductible applies. No charge/visit, preventive care visit, including routine prenatal obstetrical visits; deductible does not apply.	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance; deductible applies.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Childbirth/delivery facility services	40% coinsurance; deductible applies.	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance; deductible applies.	Not covered	Limited to: • 100 visits/year. • 2 hours/visit for a nurse, medical social worker, or physical, occupational, or speech therapist. • 4 hours/visit for a home health aide. Preauthorization is required, or services not covered.
	Rehabilitation services	$65 copay/office visit; deductible does not apply.	Not covered	Preauthorization is required, or services not covered.
	Habilitation services	$65 copay/office visit; deductible does not apply.	Not covered	
	Skilled nursing care	40% coinsurance; deductible applies.	Not covered	100 days/year limit. Preauthorization is required, or services not covered.
	Durable medical equipment	40% coinsurance; deductible applies.	Not covered	Preauthorization is required, or services not covered.
	Hospice services	No charge; deductible does not apply.	Not covered	Prior notification is required.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply.	Not covered	1 exam/year limit.
	Children's glasses	No charge; deductible does not apply.	Not covered	Limited to 1 pair of prescription glasses (frames and lenses), or contact lenses in lieu of glasses, every year. Greater quantities are available for certain kinds of contact lenses.
	Children's dental check-up	No charge; deductible does not apply.	Not covered	Plan pays 100% for preventive exams twice per year. See your policy or plan document for additional information about services.

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.)		
• Chiropractic care	• Infertility treatment	• Private duty nursing
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care
• Hearing aids		• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Acupuncture (if prescribed for nausea or chronic pain)	• Bariatric surgery

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: Department of Managed Health Care at 1 (888) HMO-2219 (1-888-466-2219) or dmhc.ca.gov, and Covered California at 1 (800) 300-1506 or coveredca.com. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Managed Health Care at 1 (888) HMO-2219 (1-888-466-2219) or dmhc.ca.gov.

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? **Not Applicable.**
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.

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

The plan's overall deductible	**$6,300**
Specialist copayment	**$95**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles*	$6,300
Copayments	$500
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,200**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$6,300**
Specialist copayment	**$95**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$2,100
Copayments	$400
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$6,300**
Specialist copayment	**$95**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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:	
Cost Sharing	
Deductibles*	$2,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019; TTY (800) 537-7697.

Grievances – The grievance procedure is available in the section of the Agreement titled “Complaints and Appeals.” Please refer to that section for how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the DMHC for review after completing the grievance process or participating in the process for at least 30 days.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會 員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)