




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 our website at MolinaMarketplace.com or call 1-888-560-5716. 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 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?	\$2,500 individual / \$5,000 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 , office visits, urgent care , rehabilitation services , habilitation services , diagnostic tests , inpatient services , home healthcare , and preferred generic & brand drugs 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. \$2,500 individual / \$5,000 family for prescription drug coverage . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers \$9,100 individual / \$18,200 family; for out-of-network providers, there is no coverage unless Prior Authorized by Molina Healthcare.	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 1-888-560-5716 for a list of network providers .	You pay the least if you use a provider in Choice Hospital/Facility Network ("Choice Network"). You pay more if you use a provider in Select Hospital/Facility Network ("Select 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

Important Questions	Answers	Why This Matters:
		billing).
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	\$30 copay /visit	Not covered	None
	Specialist visit	\$60 copay /visit	Not covered	Preauthorization may be required, or services not covered.
	Preventive care/screening /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Choice Hospital/Facility Network: \$95 copay for x-rays; \$60 copay for blood work Select Hospital/Facility Network: \$190 copay for x-rays; \$120 copay for blood work	Not covered	None
	Imaging (CT/PET scans, MRIs)	Choice Hospital/Facility Network: 35% coinsurance after deductible Select Hospital/Facility Network: 50% coinsurance after deductible	Not covered	Preauthorization is required or Imaging services are not covered.
If you need drugs to treat your illness or condition More information about	Generic drugs - Preferred (Tier 1)	\$29 copay /prescription (retail); deductible does not apply	Not covered	Preauthorization may be required, or services may be not covered. Up to 30-day supply retail. For tiers 1, 2 and 3, up to 90-day supply by mail order offered at two-and-
	Preferred brand drugs (Tier 2)	\$60 copay /prescription (retail); deductible does not apply	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)	
prescription drug coverage is available at MolinaMarketplace.com/FLFormulary2023	Non-preferred brand drugs and non-preferred generic drugs (Tier 3)	50% coinsurance after deductible (retail)	Not covered	a-half times the 30-day retail cost-sharing . For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug cost-sharing assistance will not apply toward any deductibles or annual out-of-pocket limit .
	Specialty drugs (Tier 4)	50% coinsurance after deductible (retail)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Choice Hospital/Facility Network: 35% coinsurance after deductible Select Hospital/Facility Network: 50% coinsurance after deductible	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	35% coinsurance after deductible	Not covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	\$950 copay	\$950 copay	Cost-sharing for emergency room care does not apply if admitted to the hospital.
	Emergency medical transportation	35% coinsurance after deductible	35% coinsurance after deductible	
	Urgent care	\$30 copay /visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Choice Hospital/Facility Network: \$1,200 copay /day Select Hospital/Facility Network: \$2,400 copay /day	Not covered	Preauthorization is required or services not covered. Maximum two days of facility copayments per inpatient admission.
	Physician/surgeon fees	\$60 copay /visit	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit	Not covered	Preauthorization is required for inpatient care or services not covered. Maximum two days of facility copayments per inpatient admission.
	Inpatient services	Choice Hospital/Facility Network: \$1,200 copay /day facility; \$60 copay /visit professional fee Select Hospital/Facility Network: \$2,400 copay /day facility; \$60 copay /visit professional fee	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 are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Maximum two days of facility copayments per inpatient admission.
	Childbirth/delivery professional services	\$60 copay /visit	Not covered	
	Childbirth/delivery facility services	<i>Choice Hospital/Facility Network:</i> \$1,200 copay /day <i>Select Hospital/Facility Network:</i> \$2,400 copay /day	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to: <ul style="list-style-type: none"> Up to two hours per visit for nursing care by a registered nurse, licensed practical nurse, medical social worker, physician, occupational or speech therapist Up to 60 visits per calendar year Preauthorization may be required, or services may be not covered.
	Rehabilitation services	\$60 copay /visit	Not covered	Limited to a total of 35 visits per year for any combination of the following therapies: <ul style="list-style-type: none"> Physical, Speech, Occupational, Cardiac Rehabilitation, Massage and Spinal Manipulative Therapy The 35 visits include a 26-visit limit for spinal manipulation. Preauthorization may be required, or services may be not covered.
	Habilitation services	\$60 copay /visit	Not covered	None
	Skilled nursing care	<i>Choice Hospital/Facility Network:</i> \$1,200 copay /day <i>Select Hospital/Facility Network:</i> \$2,400 copay /day	Not covered	Limited to 60 days per calendar year. Preauthorization may be required, or services may be not covered.
	Durable medical equipment	35% coinsurance after deductible	Not covered	Preauthorization may be required, or services may be not covered.
	Hospice services	No charge	Not covered	Preauthorization may be required, or

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)	
				services may be not covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One screening/exam per calendar year
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses (lenses and frames) or contact lenses in lieu of prescription glasses/year. Laser corrective surgery not covered.
	Children's dental check-up	Not covered	Not covered	None

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 .)		
<ul style="list-style-type: none"> • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Dental care (Adult) • Hearing aids • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Weight loss programs 	

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: Florida Department of Financial Services 1-877-693-5236. 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: Florida Department of Financial Services 1-877-693-5236.

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	\$2,500
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$1,200
■ Other coinsurance	35%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,100
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Peg would pay is	\$2,100
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$1,200
■ Other coinsurance	35%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$1,400
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Joe would pay is	\$2,200
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$60
■ Hospital (facility) copayment	\$1,200
■ Other coinsurance	35%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$900
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$2,100
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



Your Extended Family.

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.

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: Չանգահարել՝ չանախորդների 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 ਸਰਵਿਸਜ਼ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)