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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in the chart starting on page 2.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,625 individual / $3,250 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 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	No charge Deductible does not apply	Not covered	None
	Specialist visit	$10 copay/visit Deductible does not apply	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*: $20 copay for x-rays; $8 copay for blood work Deductible does not apply *Select Hospital/Facility Network*: $40 copay for x-rays; $16 copay for blood work Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	*Choice Hospital/Facility Network*: 20% coinsurance Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance Deductible does not apply	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	No charge (retail) Deductible does not apply	Not covered	Preauthorization may be required, or services may be not covered. Up to 30-day supply retail. Up to 90-day supply by mail order offered at two-and-a-half times the 30-
	Preferred brand drugs	$30 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/FLFormulary2024	Non-preferred brand drugs and non-preferred generic drugs	20% coinsurance (retail) Deductible does not apply	Not covered	day retail cost-sharing. Mail order not available for Specialty drugs. 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	20% coinsurance Deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Choice Hospital/Facility Network*: 20% coinsurance Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance Deductible does not apply	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% coinsurance Deductible does not apply	Not covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	20% coinsurance Deductible does not apply	20% coinsurance Deductible does not apply	Cost-sharing for emergency room care does not apply if admitted to the hospital.
	Emergency medical transportation	20% coinsurance Deductible does not apply	20% coinsurance Deductible does not apply	
	Urgent care	$5 copay/visit Deductible does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	*Choice Hospital/Facility Network*: 20% coinsurance Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance Deductible does not apply	Not covered	Preauthorization is required or services 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)	
	Physician/surgeon fees	20% coinsurance Deductible does not apply	Not covered	
If you need mental health, behavioral health, or substance abuse services FL24SBCE_S9_6	Outpatient services	No charge Deductible does not apply	Not covered	None.
	Inpatient services	*Choice Hospital/Facility Network*: 20% coinsurance facility; 20% coinsurance professional fee Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance facility; 20% coinsurance professional fee Deductible does not apply	Not covered	Preauthorization is required for inpatient care or services not covered.
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).
	Childbirth/delivery professional services	20% coinsurance Deductible does not apply	Not covered	
	Childbirth/delivery facility services	*Choice Hospital/Facility Network*: 20% coinsurance Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance Deductible does not apply	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to: • 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

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.
	Rehabilitation services	$5 copay/visit Deductible does not apply	Not covered	Limited to a total of 35 visits per year for any combination of the following therapies: • 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	$5 copay/visit Deductible does not apply	Not covered	None
	Skilled nursing care	*Choice Hospital/Facility Network*: 20% coinsurance Deductible does not apply *Select Hospital/Facility Network*: 40% coinsurance Deductible does not apply	Not covered	Limited to 60 days per calendar year. Preauthorization may be required, or services may be not covered.
	Durable medical equipment	20% coinsurance Deductible does not apply	Not covered	Preauthorization may be required, or services may be not covered.
	Hospice services	No charge	Not covered	Preauthorization may be required, or 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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- 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	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$200
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,600**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Copayments	$90
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

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 https://www.hhs.gov/ocr/complaints/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.

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ATTENTION: Aids and services for people with disabilities, like documents in braille and large print, arealso available. If you need help in your language call Member Services located on back of your ID card.(TTY: 711). These services are free of charge.

ATENCIÓN: Si necesita ayuda en su idioma llame a Servicios para Miembros. El número está en el reverso de su tarjeta de identificación de miembro. (TTY: 711). También hay disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Estos serviciosson gratuitos. (Spanish)

. تنبه: إذا كنت بحاجة الى مساعدة في لغتك ، فاتصل، بخدمات الأعضاء. الرقم موجود على ظهر بطاقة هوية العضو الخاصة بك |
(Arabic) .(الهاتف النصي: 711). تتوفر أيضا مساعدات وخدمات للأشخاص ذوي الإعاقة، مثل المستندات بطريقة برايل والطباعة الكبيرة. هذه الخدمات مجانية

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք Member Services: Համարը գտնվում է Ձեր Member ID քարտիետևի մասում: (TTY: 711):
Առկա են նաեւ հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ եւ ծառայություններ, ինչպես բրեյլի եւ մեծ տպաքանակի փաստաթղթեր: Այս ծառայությունները անվճար են: (Armenian)

ការយកចំនុចទុកដាក់៖ជំនួយនឹងសេវាកម្មសម្រាប់ជនពិការរួចជាឯកសារក្នុងអក្សរទ្រនាប់នឹងព្រីនធំក៏មានផងដែរ.
ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការហៅភាសារបស់អ្នកថាសមាជិកសេវាកម្មដែលមានទីតាំងនៅខាងក្រោយអនុសញ្ញាណប័ណ្ណរបស់អ្នក, (TTY: ៧១១), សេវាកម្មទាំងនេះដោយមិនគិតថ្លៃ, (Cambodian)

注意:如果您需要语言方面的帮助, 请致电会员服务部。该号码位于您的会员 ID 卡背面。(TTY: 711)。
还为残疾人提供辅助工具和服务, 如盲文和大字体文件。这些服务是免费的。(Chinese Simplified)

توجه: کمک ها و خدمات برای افراد معلول, مانند اسناد بریل
. و چاپ بزرگ نیز در دسترس هستند. در صورت نیاز به کمک در زبان خود با خدمات عضو واقع در پشت کارت شناسایی خود تماس بگیرید
(Farsi) .این خدمات رایگان هستند . (TTY: 711)

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता है, तो सदस्य सेवाओं को कॉल करें। नंबर आपके सदस्य आईडी कार्ड के पीछे है। (TTY: 711)। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज, भी उपलब्ध हैं। ये सेवाएं नि: शुल्क हैं। (Hindi)

XIM: Yog koj xav tau kev pab los ntawm koj cov kev pab. Tus naj npawb nyob sab nraum qab ntawm koj tus ID card. (TTY: 711).
Aids thiab kev pab rau cov neeg uas muaj mob xiam oob qhab, xws li cov ntaub ntawv nyob rau hauv braille thiab loj print, kuj muaj. Cov kev pab no yog pab dawb xwb. (Hmong)

ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, rufen Sie den Mitgliederservice an. Die Nummer finden Sie auf der Rückseite Ihres Mitgliedsausweises. (TTY: 711).
Hilfsmittel und Dienstleistungen für Menschen mit Behinderungen, wie Dokumente in Blindenschrift und Großdruck, sind ebenfalls verfügbar. Diese Dienstleistungen sind kostenlos. (German)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese

注意:あなたの言語で助けが必要な場合は、メンバーサービスに電話してください。番号は会員証の裏面に記載されています。(TTY: 711)。
点字や大活字の書類など、障害者のための援助やサービスも利用できます。これらのサービスは無料です。(Japanese)

주의: 귀하의 언어로 도움이 필요하면 회원 서비스에 전화하십시오. 이 번호는 가입자 ID 카드 뒷면에 있습니다. (TTY: 711) 입니다.
점자 및 큰 활자로 된 문서와 같은 장애인을 위한 보조 및 서비스도 제공됩니다. 이러한 서비스는 무료입니다. (Korean)

ຂໍ້ຄວນລະວັງ: Aids ແລະການບໍລິການສຳລັບຄົນພິການ, ເຊັ່ນດຽວກັບເອກະສານໃນ braille ແລະການພິມຂະຫນາດໃຫຍ່, ຍັງມີ. ຖ້າ ທ່ານ ຕ້ອງ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ ທ່ານ. (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਮੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711).
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711). Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print.
Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711).
Ang mga serbisyong ito ay libre. (Tagalog)

ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโทรติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711)
นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711). Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).
Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)

Languages: English, Spanish, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, German, Japanese, Korean, Loatian, Mien, Punjabi, Russian, Tagalog, Thai, Ukrainian, Vietnamese