



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](https://www.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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-318-2596 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>Deductible</u>?</b>                             | \$0 / individual or \$0 / family                                                                                                                                          | Generally, you must pay all of the costs from <u>providers</u> 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> .                                                                                                                                                               |
| <b>Are there services covered before you meet your <u>Deductible</u>?</b> | Yes. <u>Preventive care</u> and services indicated in the chart starting on page 2.                                                                                       | 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 services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| <b>Are there other <u>Deductibles</u> for specific services?</b>          | Yes. \$5000 individual / \$10000 family for <u>prescription drug coverage</u> . There are no other specific <u>Deductibles</u> .                                          | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For network <u>providers</u> \$10350 individual / \$20700 family; for <u>out-of-network</u> providers, there is no coverage unless Prior Authorized by Molina Healthcare. | 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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://www.molinamarketplace.com">Molinamarketplace.com</a> or call 1-888-560-5716 for a list of <u>network 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 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. |

| Important Questions                                        | Answers | Why This Matters:                                                |
|------------------------------------------------------------|---------|------------------------------------------------------------------|
| 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 referral. |

 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<br>(You will pay the least)                                                                                | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you visit a health care <u>provider's</u> office or clinic</b>                                                                                                          | Primary care visit to treat an injury or illness          | \$50 <u>copay</u> /visit; <u>Deductible</u> does not apply                                                                        | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                               | <u>Specialist</u> visit                                   | \$125 <u>copay</u> /visit; <u>Deductible</u> does not apply                                                                       | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                               | <u>Preventive care/screening/immunization</u>             | 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.                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have a test</b>                                                                                                                                                     | <u>Diagnostic test</u> (x-ray, blood work)                | \$150 <u>copay</u> for x-rays <u>Deductible</u> does not apply; \$75 <u>copay</u> for blood work <u>Deductible</u> does not apply | Not covered                                           | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                              | \$1500 <u>copay</u> <u>Deductible</u> does not apply                                                                              | Not covered                                           | <u>Preauthorization</u> is required or Imaging services are not covered                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at MolinaMarketplace.com/FLFormulary2026 | Generic drugs - preferred                                 | \$25 <u>copay</u> /prescription (retail) <u>Deductible</u> does not apply                                                         | Not covered                                           | <u>Deductible</u> applies for Preferred brand drugs, Non-preferred brand and non-preferred generic drugs and <u>Specialty drugs</u> . <u>Preauthorization</u> may be required, or services may not be covered. Certain prescription drugs are available for up to a 90-day extended supply at network retail pharmacies or a mail order option. Cost sharing for an extended supply is three times (3x) the 30-day retail <u>cost sharing</u> . Mail order not available for <u>Specialty drugs</u> . For brand |
|                                                                                                                                                                               | Preferred brand drugs                                     | \$125 <u>copay</u> /prescription (retail)                                                                                         | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                               | Non-preferred brand drugs and non-preferred generic drugs | 50% <u>coinsurance</u> (retail)                                                                                                   | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                               | <u>Specialty drugs</u>                                    | 50% <u>coinsurance</u>                                                                                                            | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                                                                                                                              |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                         |
|---------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Participating Provider<br>(You will pay the least)                                                                                             | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                |
|                                                                           |                                                |                                                                                                                                                |                                                       | drugs with a generic equivalent, coupons or any other form of third-party prescription drug <u>cost-sharing</u> assistance will not apply toward any <u>Deductibles</u> or annual <u>out-of-pocket limit</u> . |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | \$1750 <u>copay</u><br><u>Deductible</u> does not apply                                                                                        | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                              |
|                                                                           | Physician/surgeon fees                         | \$600 <u>copay</u> <u>Deductible</u> does not apply                                                                                            | Not covered                                           | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                              |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                     | \$1750 <u>copay</u><br><u>Deductible</u> does not apply                                                                                        | \$1750 <u>copay</u> <u>Deductible</u> does not apply  | <u>Cost-sharing</u> for <u>emergency room care</u> does not apply if admitted to the hospital.                                                                                                                 |
|                                                                           | <u>Emergency medical transportation</u>        | \$1750 <u>copay</u><br><u>Deductible</u> does not apply                                                                                        | \$1750 <u>copay</u> <u>Deductible</u> does not apply  |                                                                                                                                                                                                                |
|                                                                           | <u>Urgent care</u>                             | \$50 <u>copay/visit</u><br><u>Deductible</u> does not apply                                                                                    | Not covered                                           | None.                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | \$3,000 <u>copay/day</u><br><u>Deductible</u> does not apply                                                                                   | Not covered                                           | <u>Preauthorization</u> is required or services not covered. Maximum three days of facility <u>copayments</u> per inpatient admission.                                                                         |
|                                                                           | Physician/surgeon fees                         | \$125 <u>copay/day</u><br><u>Deductible</u> does not apply                                                                                     | Not covered                                           |                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | \$50 <u>copay/visit</u> ;<br><u>Deductible</u> does not apply                                                                                  | Not covered                                           | None.                                                                                                                                                                                                          |
|                                                                           | Inpatient services                             | \$3,000 <u>copay/day</u> (facility) <u>Deductible</u> does not apply; \$125 <u>copay/visit</u> (professional) <u>Deductible</u> does not apply | Not covered                                           | <u>Preauthorization</u> is required for inpatient care or services not covered. Maximum three days of facility <u>copayments</u> per inpatient admission.                                                      |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                             |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Participating Provider<br>(You will pay the least)            | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                     |
| If you are pregnant                                            | Office visits                             | No charge                                                     | Not covered                                           | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Maximum three days of facility <u>copayments</u> per inpatient admission.                                                                     |
|                                                                | Childbirth/delivery professional services | \$125 <u>copay</u> /visit<br><u>Deductible</u> does not apply | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | Childbirth/delivery facility services     | \$3,000 <u>copay</u> /day<br><u>Deductible</u> does not apply | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 50% <u>coinsurance</u><br><u>Deductible</u> does not apply    | Not covered                                           | Limited to: <ul style="list-style-type: none"> <li>Up to two hours per visit for nursing care by a registered nurse, licensed practical nurse, medical social worker, physician, occupational or speech therapist</li> <li>Up to 20 days per calendar year</li> </ul> <u>Preauthorization</u> may be required, or services may not be covered.                                      |
|                                                                | <u>Rehabilitation services</u>            | \$90 <u>copay</u> /visit;<br><u>Deductible</u> does not apply | Not covered                                           | Limited to a total of 35 visits per year for any combination of the following therapies: <ul style="list-style-type: none"> <li>Physical, Speech, Occupational, Cardiac Rehabilitation, Massage and Spinal Manipulative Therapy</li> </ul> The 35 visits include a 26-visit limit for spinal manipulation. <u>Preauthorization</u> may be required, or services may not be covered. |
|                                                                | <u>Habilitation services</u>              | \$90 <u>copay</u> /visit;<br><u>Deductible</u> does not apply | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                | <u>Skilled nursing care</u>               | \$3,000 <u>copay</u> /day<br><u>Deductible</u> does not apply | Not covered                                           | Limited to 60 days per calendar year. <u>Preauthorization</u> may be required, or services may not be covered.                                                                                                                                                                                                                                                                      |
|                                                                | <u>Durable medical equipment</u>          | 50% <u>coinsurance</u><br><u>Deductible</u> does not apply    | Not covered                                           | <u>Preauthorization</u> may be required, or services may not be covered.                                                                                                                                                                                                                                                                                                            |
|                                                                | <u>Hospice services</u>                   | No charge                                                     | Not covered                                           | <u>Preauthorization</u> may be required, or services may not be covered.                                                                                                                                                                                                                                                                                                            |
|                                                                |                                           |                                                               |                                                       |                                                                                                                                                                                                                                                                                                                                                                                     |
| If your child needs                                            | Children's eye exam                       | No charge                                                     | Not covered                                           | One screening/exam per calendar year                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event | Services You May Need      | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                    |
|----------------------|----------------------------|----------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                           |
| dental or eye care   | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)                                               |                                                                                                                       |                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                                                                  |                                                                                                                       |                                                                                                                                                               |  |
| <ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Dental care (Adult)</li> </ul>                                                                                                                     | <ul style="list-style-type: none"> <li>Weight loss programs</li> </ul>                                                | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>                                                                                    |  |

**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](http://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 <u>plan's</u> overall <u>Deductible</u> | \$0    |
| ■ <u>Specialist copayment</u>                 | \$125  |
| ■ Hospital (facility) <u>copayment</u>        | \$3000 |
| ■ Other <u>coinsurance</u>                    | 0%     |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |               |
|-----------------------------------|---------------|
| <u>Deductibles</u>                | \$0           |
| <u>Copayments</u>                 | \$4200        |
| <u>Coinsurance</u>                | \$0           |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$0           |
| <b>The total Peg would pay is</b> | <b>\$4200</b> |

### Managing Joe's Type 2 Diabetes

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

|                                               |        |
|-----------------------------------------------|--------|
| ■ The <u>plan's</u> overall <u>Deductible</u> | \$0    |
| ■ <u>Specialist copayment</u>                 | \$125  |
| ■ Hospital (facility) <u>copayment</u>        | \$3000 |
| ■ Other <u>coinsurance</u>                    | 0%     |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |               |
|-----------------------------------|---------------|
| <u>Deductibles</u>                | \$3100        |
| <u>Copayments</u>                 | \$4200        |
| <u>Coinsurance</u>                | \$400         |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$0           |
| <b>The total Joe would pay is</b> | <b>\$4400</b> |

### 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 copayment</u>                 | \$125  |
| ■ Hospital (facility) <u>copayment</u>        | \$3000 |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |               |
|-----------------------------------|---------------|
| <u>Deductibles</u>                | \$0           |
| <u>Copayments</u>                 | \$2100        |
| <u>Coinsurance</u>                | \$100         |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$0           |
| <b>The total Mia would pay is</b> | <b>\$2200</b> |

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