Molina Healthcare of Florida, Inc.:
Molina Bronze Premier with $0 Medical Deductible LCS Plus with Adult Vision

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 at an Indian Health Care Provider (IHCP) or with IHCP referral to a non-IHCP, or $0 / individual or $0 / 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 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?	Yes. $5000 individual / $10000 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 $10350 individual / $20700 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.	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the Specialist 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network 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	$50 copay/visit; Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Specialist visit	No charge	$125 copay/visit; Deductible does not apply	Not covered	Preauthorization may be required, or services not covered. Cost sharing waived at non-IHCP with IHCP referral.
	Preventive care/screening/ immunization	No charge	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)	No charge	$150 copay for x-rays Deductible does not apply; $75 copay for blood work Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	$1500 copay Deductible does not apply	Not covered	Preauthorization is required or Imaging services are not covered. Cost sharing waived at non-IHCP with IHCP referral.
If you need drugs to treat your illness or condition More information about **prescription drug**	Generic drugs - preferred	No charge	$25 copay/prescription (retail) Deductible does not apply	Not covered	Deductible applies for Preferred brand drugs, Non-preferred brand and non-preferred generic drugs and Specialty drugs. Preauthorization may be required, or services may not
	Preferred brand drugs	No charge	$125 copay/prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
coverage is available at MolinaMarketplace.com/FLFormulary2026			(retail)		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 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. Cost sharing waived at non-IHCP with IHCP referral.
	Non-preferred brand drugs and non-preferred generic drugs	No charge	50% coinsurance (retail)	Not covered	
	Specialty drugs	No charge	50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$1750 copay Deductible does not apply	Not covered	Preauthorization may be required, or services not covered. Cost sharing waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	$600 copay Deductible does not apply	Not covered	Preauthorization may be required, or services not covered. Cost sharing waived at non-IHCP with IHCP referral.
If you need immediate medical attention	Emergency room care	No charge	$1750 copay Deductible does not apply	$1750 copay Deductible does not apply	Cost-sharing for emergency room care does not apply if admitted to the hospital. Cost sharing waived at non-IHCP with IHCP referral.
	Emergency medical transportation	No charge	$1750 copay Deductible does not apply	$1750 copay Deductible does not apply	
	Urgent care	No charge	$50 copay/visit Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$3,000 copay/day Deductible does not	Not covered	Preauthorization is required or services not covered. Cost sharing

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
			apply (Maximum three days of facility copayments per inpatient admission)		waived at non-IHCP with IHCP referral.
	Physician/surgeon fees	No charge	$125 copay/day Deductible does not apply	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$50 copay/visit; Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Inpatient services	No charge	$3,000 copay/day (facility) Deductible does not apply; $125 copay/day (professional) Deductible does not apply	Not covered	Preauthorization is required for inpatient care or services not covered. Cost sharing waived at non-IHCP with IHCP referral.
If you are pregnant	Office visits	No charge	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	$125 copay/day Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Childbirth/delivery facility services	No charge	$3,000 copay/day Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
If you need help recovering or have other special health	Home health care	No charge	50% coinsurance Deductible does not apply	Not covered	Limited to: • Up to two hours per visit for nursing care by a registered

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
needs					nurse, licensed practical nurse, medical social worker, physician, occupational or speech therapist • Up to 20 days per calendar year Preauthorization may be required, or services may not be covered. Cost sharing waived at non-IHCP with IHCP referral.
	Rehabilitation services	No charge	$90 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 not be covered. Cost sharing waived at non-IHCP with IHCP referral.
	Habilitation services	No charge	$90 copay/visit; Deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral.
	Skilled nursing care	No charge	$3,000 copay/day Deductible does not apply	Not covered	Limited to 60 days per calendar year. Preauthorization may be required, or services may not be covered. Cost sharing waived at non-IHCP with IHCP referral.
	Durable medical equipment	No charge	50% coinsurance Deductible does not apply	Not covered	Preauthorization may be required, or services may not be covered. Cost sharing waived at non-IHCP with IHCP referral.
	Hospice services	No charge	No charge	Not covered	Preauthorization may be required, or services may not be covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	One screening/exam per calendar year
	Children's glasses	No charge	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	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 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
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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	**$125**
Hospital (facility) copayment	**$3000**
Other coinsurance	**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)*

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

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	**$125**
Hospital (facility) copayment	**$3000**
Other coinsurance	**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)*

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

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

The plan's overall Deductible	**$0**
Specialist copayment	**$125**
Hospital (facility) copayment	**$3000**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.