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?	$5750 / individual or $11500 / 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?	No.	You don't have to meet Deductible for specific services.
What is the out-of-pocket limit for this plan?	For network providers $9,050 individual / $18,100 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?	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
		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; Deductible does not apply	Not covered	None
	Specialist visit	$60 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*: $95 copay for x-rays; $60 copay for blood work Deductible does not apply *Select Hospital/Facility Network*: $190 copay for x-rays; $120 copay for blood work Deductible does not apply	Not covered	None.
	Imaging (CT/PET scans, MRIs)	*Choice Hospital/Facility Network*: 35% coinsurance *Select Hospital/Facility Network*: 50% coinsurance	Not covered	Deductible applies. Preauthorization is required or Imaging services are not covered
If you need drugs to treat your illness or condition	Generic drugs - preferred	$15 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.

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)	
More information about **prescription drug coverage** is available at MolinaMarketplace.com/FLFormulary2026	Preferred brand drugs	$65 copay/prescription (retail)	Not covered	Preauthorization 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 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.
	Non-preferred brand drugs and non-preferred generic drugs	35% coinsurance (retail)	Not covered	
	Specialty drugs	35% coinsurance (retail)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Choice Hospital/Facility Network*: 35% coinsurance *Select Hospital/Facility Network*:50 % coinsurance	Not covered	Deductible applies. Preauthorization may be required, or services not covered.
	Physician/surgeon fees	35% coinsurance	Not covered	Deductible applies. Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	35% coinsurance	35% coinsurance	Deductible applies. Cost-sharing for emergency room care does not apply if admitted to the hospital.
	Emergency medical transportation	35% coinsurance	35% coinsurance	
	Urgent care	$45 copay/visit Deductible does not apply	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	*Choice Hospital/Facility Network*: 35% coinsurance *Select Hospital/Facility Network*: 50% coinsurance	Not covered	Deductible applies. Preauthorization is required or services not covered.
	Physician/surgeon fees	35% coinsurance	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 need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit; Deductible does not apply	Not covered	None.
	Inpatient services	*Choice Hospital/Facility Network*: 35% coinsurance facility; 35% coinsurance professional fee *Select Hospital/Facility Network*: 50% coinsurance facility; 35% coinsurance professional fee	Not covered	Deductible applies. 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, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	35% coinsurance	Not covered	Deductible applies.
	Childbirth/delivery facility services	*Choice Hospital/Facility Network*: 35% coinsurance *Select Hospital/Facility Network*: 50% coinsurance	Not covered	Deductible applies.
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not covered	Deductible applies. 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 20 days 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 not be covered.
	Rehabilitation services	$30 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.
	Habilitation services	$30 copay/visit Deductible does not apply	Not covered	None
	Skilled nursing care	*Choice Hospital/Facility Network*: 35% coinsurance *Select Hospital/Facility Network*: 50% coinsurance	Not covered	Deductible applies. Limited to 60 days per calendar year. Preauthorization may be required, or services may not be covered.
	Durable medical equipment	35% coinsurance	Not covered	Deductible applies. Preauthorization may be required, or services may not be covered.
	Hospice services	No charge	Not covered	Preauthorization may be required, or services may not be 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 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	**$5750**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**35%**
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5750
Copayments	$800
Coinsurance	$1900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8450**

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

The plan's overall Deductible	**$5750**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**35%**
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4500**

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

The plan's overall Deductible	**$5750**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**35%**
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2000**

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

Non-Discrimination Notice – Section 1557
Molina Healthcare of Florida - Marketplace

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin, race, or sex.

To help you effectively communicate with us, Molina Healthcare provides services free of charge and in a timely manner:

- Molina Healthcare provides reasonable modifications and appropriate aids and services to people with disabilities. This includes:(1) Qualified interpreters. (2) Written Information in other formats, such as large print, audio, accessible electronic formats, and Braille.

- Molina Healthcare provides language services to people who speak another language or have limited English skills. This includes:(1) Qualified oral interpreters. (2) Information translated in your language.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at 1-888-560-5716 or TTY/TDD: 711, Monday to Friday, 8 a.m. to 6 p.m., local time.

If you believe we have discriminated on the basis of age, color, disability, national origin, race, or sex, you can file a grievance. You can file a grievance by phone, mail, email, or online. If you need help writing your grievance, we will help you. You may obtain our grievance procedure by visiting our website at MolinaHealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx

Call our Civil Rights Coordinator at 1-866-606-3889, TTY/TDD: 711 or submit your grievance to:

Civil Rights Unit
200 Oceangate, Suite 100
Long Beach, CA 90802
Email: Civil.Rights@MolinaHealthcare.com
Website: MolinaHealthcare.Alertline.com

You can also file a civil rights complaint (grievance) with the U.S. Department of Health and Human Services, Office for Civil Rights, online through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

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

Phone: 1-800-368-1019
TTY/TDD: 800-537-7697

Complaint forms are available here: https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf

Notice of Availability – Section 1557
Molina Healthcare of Florida - Marketplace

English	For free language assistance services, and auxiliary aids and services, call 1-888-560-5716 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-560-5716 (TTY: 711).
French Creole Kreyòl Ayisyen	Pou asistans lang gratis, epi èd ak sèvis oksilyè, rele 1-888-560-5716 (TTY: 711).
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-888-560-5716 (TTY: 711).
Portuguese Português	Para obter serviços de assistência linguística e materiais e serviços auxiliares gratuitos ligue para 1-888-560-5716 (telefone de texto [TTY]: 711).
Chinese (Traditional) 中文（台灣繁體）	如需免費的語言協助服務以及輔助裝置和服務，請致電 1-888-560-5716（聽障專線：711）。
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-560-5716 (ATS : 711).
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-560-5716 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-560-5716 (телетайп: 711).
Arabic العربية	اتصل عىل الرقم 1-888-560-5716 (الهاتف النص 711 :(TTY)) لتليق خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Italian Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-888-560-5716 (TTY: 711).
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-560-5716 (TTY: 711).
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-888-560-5716 (TTY: 711)로 연락 주시기 바랍니다.

Polish Polski	Aby uzyskać bezpłatną pomoc językową oraz dodatkowe wsparcie i usługi, należy zadzwonić pod numer 1-888-560-5716 (TTY: 711).
Gujarati ગુજરાતી	મફત ભાષા સહયોગ સેવાઓ અને સહાયક સાધનો તથા સેવાઓ માટે 1-888-560-5716 (TTY: 711) પર કૉલ કરો.
Thai ไทย	สำหรับบริการช่วยเหลือฟรีด้านภาษาและบริการเสริม โปรดโทร 1-888-560-5716 (TTY: 711)