



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://MolinaMarketplace.com) or call 1-888-560-4087. 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 [www.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 deductible?</b>                             | \$0                                                                                                                                                                      | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> and services indicated 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 deductibles for specific services?</b>          | No.                                                                                                                                                                      | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>network providers</u> \$2,000 individual / \$4,000 family; for <u>out-of-network providers</u> there is no coverage unless Prior Authorized by Molina Healthcare. | The <u>out-of-pocket limit</u> out-of-pocket limit 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 out-of-pocket limit?</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 network provider?</b>            | Yes. See <a href="https://MolinaMarketplace.com/MIFindCare">MolinaMarketplace.com/MIFindCare</a> or call 1-888-560-4087 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 plan's <u>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 provider's 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. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                      | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

 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                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                           |                                                  | Network Provider<br>(You will pay the least)                               | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                             | Primary care visit to treat an injury or illness | \$0 <u>Copay</u> /visit; <u>deductible</u> does not apply                  | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                           | <u>Specialist</u> visit                          | \$10 <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 <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your plan will pay for.                                                                                                                                                                                                                                                                           |
| <b>If you have a test</b>                                                                                                                                                                                                                 | <u>Diagnostic test</u> (x-ray, blood work)       | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply                  | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                     | 25% <u>Coinsurance</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 <a href="https://MolinaMarketplace.com/MIFormulary2025">MolinaMarketplace.com/MIFormulary2025</a> | Generic drugs                                    | \$0 <u>Copay</u> /prescription (retail); <u>deductible</u> does not apply  | Not Covered                                        | <u>Preauthorization</u> may be required, or services not covered. Mail-order <u>Prescription Drugs</u> are available at a 90-day supply and is offered at three times the 30-day retail prescription <u>Cost Sharing</u> .<br>For brand name drugs with a generic equivalent, coupons or any other form of third-party <u>prescription drug</u> cost sharing assistance will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limits</u> . |
|                                                                                                                                                                                                                                           | Preferred brand drugs                            | \$15 <u>Copay</u> /prescription (retail); <u>deductible</u> does not apply | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                           | Non-preferred brand drugs                        | \$50 <u>Copay</u> /prescription (retail); <u>deductible</u> does not apply | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                           | <u>Specialty drugs</u>                           | \$150 <u>Copay</u> /prescription; <u>deductible</u> does not apply         | Not Covered                                        | <u>Preauthorization</u> is required, or services not covered. Mail order not available.                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you have outpatient</b>                                                                                                                                                                                                             | Facility fee (e.g., ambulatory                   | 25% <u>Coinsurance</u> ;                                                   | Not Covered                                        | <u>Preauthorization</u> may be required, or                                                                                                                                                                                                                                                                                                                                                                                                                  |

\* For more information about limitations and exceptions, see the plan or policy document at MolinaMarketplace.com

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                         |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                 |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)              | Out-of-Network Provider<br>(You will pay the most)        |                                                                                                                                                                                                                                        |
| <b>surgery</b>                                                                   | surgery center)                           | <u>deductible</u> does not apply                          |                                                           | services not covered.                                                                                                                                                                                                                  |
|                                                                                  | Physician/surgeon fees                    | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               | <u>Preauthorization</u> may be required, or services not covered.                                                                                                                                                                      |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | 25% <u>Coinsurance</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>   | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply |                                                                                                                                                                                                                                        |
|                                                                                  | <u>Urgent care</u>                        | \$5 <u>Copay</u> /visit; <u>deductible</u> does not apply | Not Covered                                               | None                                                                                                                                                                                                                                   |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)        | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               | <u>Preauthorization</u> is required or services not covered.                                                                                                                                                                           |
|                                                                                  | Physician/surgeon fees                    | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               |                                                                                                                                                                                                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$0 <u>Copay</u> /visit; <u>deductible</u> does not apply | Not Covered                                               | <u>Preauthorization</u> is required for inpatient care or services not covered.                                                                                                                                                        |
|                                                                                  | Inpatient services                        | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               |                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                             | No charge                                                 | Not Covered                                               | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                                  | Childbirth/delivery professional services | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               |                                                                                                                                                                                                                                        |
|                                                                                  | Childbirth/delivery facility services     | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                               |                                                                                                                                                                                                                                        |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                         |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | Network Provider<br>(You will pay the least)              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | No charge                                                 | Not Covered                                        | Services must be provided by an in-network home health agency. <u>Preauthorization</u> may be required, or services may not be covered.                                                                                                                                                                                                                                                                                                         |
|                                                                       | <u>Rehabilitation services</u>   | \$0 <u>Copay</u> /visit; <u>deductible</u> does not apply | Not Covered                                        | 30 visits/ calendar year Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year). Speech Therapy (limited to 30 visits per calendar year). Cardiac Rehabilitation and Pulmonary Rehabilitation (combined benefit limit of 30 visits per calendar year). Breast Cancer Rehabilitation. <u>Preauthorization</u> may be required, or services not covered. |
|                                                                       | <u>Habilitation services</u>     | \$0 <u>Copay</u> /visit; <u>deductible</u> does not apply | Not Covered                                        | 30 visits/ calendar year Physical and Occupational Therapy (including osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year). Speech Therapy (Limit of 30 visits per calendar year). <u>Preauthorization</u> may be required or services not covered.                                                                                                                                               |
|                                                                       | <u>Skilled nursing care</u>      | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                        | 45 days/calendar year. <u>Preauthorization</u> is required or services not covered.                                                                                                                                                                                                                                                                                                                                                             |
|                                                                       | <u>Durable medical equipment</u> | 25% <u>Coinsurance</u> ; <u>deductible</u> does not apply | Not Covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <u>Preauthorization</u> may be required, or services may not be covered.                                                                                                                                                                                                                                                                                  |
|                                                                       | <u>Hospice services</u>          | No charge                                                 | Not Covered                                        | 45 days/calendar year for facility-based care. Coverage includes inpatient and outpatient hospice care. <u>Preauthorization</u> is not required. Please notify Molina before services are rendered.                                                                                                                                                                                                                                             |
|                                                                       |                                  |                                                           |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | No charge                                                 | Not Covered                                        | Coverage limited to one exam/year.                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                       | Children's glasses               | No charge                                                 | Not Covered                                        | Coverage limited to one pair of glasses                                                                                                                                                                                                                                                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at MolinaMarketplace.com

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                               |
|----------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                      |
|                      |                            |                                              |                                                    | (lenses and frames) or contact lenses/year.<br>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>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Acupuncture</li> </ul>                                             | <ul style="list-style-type: none"> <li>• Dental Care (Child)</li> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Long-Term Care</li> </ul> | <ul style="list-style-type: none"> <li>• Adult Routine Vision</li> <li>• Private Duty Nursing</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</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>• Pregnancy termination</li> <li>• Bariatric Surgery</li> </ul>                              | <ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids</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: Michigan Department of Insurance and Financial Services (Phone: 1-877-999-6442). 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: Michigan Department of Insurance and Financial Services (Phone: 1-877-999-6442) or contact Molina Healthcare of Michigan at 1-888-560-4087.

#### 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? Yes

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>                 | \$10 |
| ■ Hospital (facility) <u>Coinsurance</u>      | 25%  |
| ■ Other <u>Coinsurance</u>                    | 25%  |

#### 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>                 | \$0            |
| <u>Coinsurance</u>                | \$2,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$2,000</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>                 | \$10 |
| ■ Hospital (facility) <u>Coinsurance</u>      | 25%  |
| ■ Other <u>Coinsurance</u>                    | 25%  |

#### 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>                | \$0          |
| <u>Copayments</u>                 | \$200        |
| <u>Coinsurance</u>                | \$200        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$400</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>                 | \$10 |
| ■ Hospital (facility) <u>Coinsurance</u>      | 25%  |
| ■ Other <u>Coinsurance</u>                    | 25%  |

#### 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>                 | \$30         |
| <u>Coinsurance</u>                | \$400        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$430</b> |

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



## **Non-Discrimination Notice – Section 1557 Molina Healthcare - Marketplace**

Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of age, color, disability, national origin (including limited English proficiency), race, or sex (consistent with the scope of sex discrimination described at § 92.101(a)).

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) Information in other formats, such as large print, audio, accessible electronic formats, 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 these services, contact Molina Member Services at 1-888-560-4087 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 <https://www.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  
Long Beach, CA 90802  
Email: [civil.rights@molinahealthcare.com](mailto:civil.rights@molinahealthcare.com)  
Website: <https://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





**Non-Discrimination Notice – Section 1557**  
**Molina Healthcare - Marketplace**

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



1557 - Notice of Availability

|                          |                                                                                                                                     |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Japanese<br>日本語          | 無料の言語サポートや補助器具・サービスをご希望の方は、1-888-560-4087 ( TTY: 711 ) までお電話ください。                                                                   |
| Russian<br>Русский       | Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-560-4087 (телетайп: 711). |
| Serbo-Croatian<br>Srpski | За бесплатну помоћ у вези са језиком и помагала и услуге, позовите 1-888-560-4087 (TTY: 711).                                       |
| Tagalog                  | Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-560-4087 (TTY: 711).                 |