Coverage Period: 01/01/2025 – 12/31/2025 Coverage for: Individual + Family | Plan Type: HMO

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 1-866-472-9484. 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This <u>plan</u> covers items and services even if you haven't yet met the <u>deductible</u> amount.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See MolinaMarketplace.com or call 1-866-472-9484 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan</u> '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 <u>provider</u> '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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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All **Copayment** and **Coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What Yo	ou Will Pay	Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Primary care visit to treat an injury or illness	No charge, <u>deductible</u> does not apply	Not Covered	None
If you visit a health care provider's office or	Specialist visit	No charge, deductible does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
clinic	Preventive care/screening/ immunization	No charge, deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	No charge, <u>deductible</u> does not apply	Not Covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge, deductible does not apply	Not Covered	Preauthorization is required or Imaging services are not covered
	Generic drugs - preferred	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered. Mail-order
If you need drugs to treat your illness or	Preferred brand drugs	No charge, deductible does not apply	Not Covered	Prescription Drugs are available at a 90-day supply and are offered at three times the 30-
condition More information about prescription drug coverage is available at http://MolinaMarketplace.com/MSFormulary2025	Non-preferred brand drugs and non-preferred generic drugs	No charge, <u>deductible</u> does not apply	Not Covered	day retail prescription Cost Sharing. For brand name 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 limits.
COM/MSFORMulary2025	Specialty drugs	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered. Mail order not available.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
surgery	Physician/surgeon fees	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
If you need immediate medical attention	Emergency room care	No charge, deductible does not apply	No charge, <u>deductible</u> does not apply	Emergency room care coinsurance does not apply, if admitted to the hospital.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider	Out-of-Network Provider	Important Information
	Emergency medical transportation	(You will pay the least) No charge, deductible does not apply No charge, deductible	(You will pay the most) No charge, deductible does not apply Not Covered	None
	<u>Urgent care</u>	does not apply	Not Covered	None
If you have a hospital	Facility fee (e.g., hospital room)	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> is required or services not covered.
stay	Physician/surgeon fees	No charge, <u>deductible</u> does not apply	Not Covered	None
If you need mental health, behavioral	Outpatient services	No charge, deductible does not apply	Not Covered	Preauthorization is required for inpatient
health, or substance abuse services	Inpatient services	No charge, <u>deductible</u> does not apply	Not Covered	care or services not covered.
	Office visits	No charge, <u>deductible</u> does not apply	Not Covered	Cost sharing does not apply to routine prenatal care and first post-natal visit and certain 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).
If you are pregnant	Childbirth/delivery professional services	No charge, <u>deductible</u> does not apply	Not Covered	
	Childbirth/delivery facility services	No charge, <u>deductible</u> does not apply	Not Covered	
	Home health care	No charge, <u>deductible</u> does not apply	Not Covered	Services must be provided by an in network Home health agency.
If you need help recovering or have	Rehabilitation services	No charge, <u>deductible</u> does not apply	Not Covered	20 combined visits/year – Physical Therapy, Occupational Therapy, Chiropractic Care 20 visits/year – Speech Therapy 36 visits/year – Cardiac Rehabilitation Preauthorization may be required, or services not covered.
other special health needs	Habilitation services	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
	Skilled nursing care	No charge, <u>deductible</u> does not apply	Not Covered	30 days/calendar year. <u>Preauthorization</u> is required or services not covered.
	Durable medical equipment	No charge, deductible does not apply	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Hospice services	No charge, <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> is not required. Please notify Molina before services are rendered.
	Children's eye exam	No charge, <u>deductible</u> does not apply	Not Covered	Coverage limited to one exam/year.
If your child needs dental or eye care	Children's glasses	No charge, <u>deductible</u> does not apply	Not Covered	Coverage limited to one pair of glasses/year.
delital of tye tale	Children's dental check-up	Not Covered	Not Covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery

- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Chiropractic care

Routine foot care

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: Molina Healthcare of Mississippi at 1-(866) 472-9484 or the Mississippi Insurance Department, P.O. Box 79, Jackson, MS 39205-0079 or phone 1-601-359-3569. 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 <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Mississippi Insurance Department, P.O. Box 79 Jackson, MS 39205-0079, or phone 601-359-3569 or contact Molina Healthcare of Mississippi at 1-(866) 472-9484.

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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>Copayments</u> and <u>Coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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
■ Specialist Copayment	\$0
■ Hospital (facility) Coinsurance	0%
■ 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	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist Copayment	\$0
■ Hospital (facility) Coinsurance	0%
■ Other <u>Coinsurance</u>	0%

This EXAMPLE event includes services like:

<u>Primary care physician</u> 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	
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist Copayment	\$0
■ Hospital (facility) Coinsurance	0%
■ Other Coinsurance	0%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

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

The <u>plan</u> 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 1-866-472-9484 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 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



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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



English	For free language assistance services, and auxiliary aids and services, call 1-866-472-9484 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-866-472-9484 (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 1-866-472-9484 (TTY: 711).
Chinese 中文(简体)	如需免费的语言协助服务以及辅助工具和服务,请致电1-866-472-9484(TTY 用户请拨打 711)。
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-866-472-9484 (ATS : 711).
Arabic العربية	اتصل على الرقم 9484-472-866-1(الهاتف النصي 711 :(TTY)) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Choctaw Chahta	Chahta anumpa ish anumpuli hokma, anumpa tohsholi yvt peh pilla ho chi apela hinla. <u>ipa</u> yah 1-866-472-9484 (TTY: 711).
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-866-472-9484 (TTY: 711).
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-866-472-9484 (TTY: 711).
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-866-472-9484 (TTY: 711)로 연락 주시기 바랍니다.
Gujarati ગુજરાતી	મફત ભાષા સહ્યોગ સેવાઓ અને સહ્યક સાધનો તથા સેવાઓ માટે 1-866-472-9484 (TTY: 711) પર કોલ કરો.



Japanese 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、1-866-472-9484(TTY: 711)までお電話ください。
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-866-472-9484 (телетайп: 711).
Panjabi ਪੰਜਾਬੀ	ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਅਤੇ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ, 1-866-472-9484 (TTY: 711) ਤੇ ਕਾਲ ਕਰੋ।
Italian Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-866-472-9484 (TTY: 711).
Hindi हिंदी	नि:शुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-866-472-9484 (TTY: 711) पर कॉल करें।