⚠️ 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 deductible?** | $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 plan covers items and services even if you haven't yet met the deductible amount. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | 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 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. |
| **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 |
| --- | --- | --- | --- | --- |
| | | Network Provider (You will pay the least) | 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, deductible does not apply | Not Covered | None |
| | Specialist visit | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. |
| | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge, deductible does not apply | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No charge, deductible does not apply | Not Covered | Preauthorization is required or Imaging services are not covered |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at http://MolinaMarketplace.com/MSFormulary2026 | Generic drugs - preferred | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. Mail-order Prescription Drugs are available at a 90-day supply and are offered at two and a half times the 30-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. |
| | Preferred brand drugs | No charge, deductible does not apply | Not Covered | |
| | Non-preferred brand drugs and non-preferred generic drugs | No charge, deductible does not apply | Not Covered | |
| | Specialty drugs | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. Mail order not available. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. |
| | Physician/surgeon fees | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | No charge, deductible does not apply | No charge, deductible does not apply | Emergency room care coinsurance does not apply, if admitted to the hospital. |
| | Emergency medical transportation | No charge, deductible does not apply | No charge, deductible does not apply | None |
| | Urgent care | No charge, deductible does not apply | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge, deductible does not apply | Not Covered | Preauthorization is required or services not covered. |
| | Physician/surgeon fees | No charge, deductible does not apply | Not Covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge, deductible does not apply | Not Covered | Preauthorization is required for inpatient care or services not covered. |
| | Inpatient services | No charge, deductible does not apply | Not Covered | |
| **If you are pregnant** | Office visits | No charge, deductible 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). |
| | Childbirth/delivery professional services | No charge, deductible does not apply | Not Covered | |
| | Childbirth/delivery facility services | No charge, deductible does not apply | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge, deductible does not apply | Not Covered | Services must be provided by an in network Home health agency. |
| | Rehabilitation services | No charge, deductible 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. |
| | Habilitation services | No charge, deductible does not apply | Not Covered | Preauthorization may be required, or services not covered. |
| | Skilled nursing care | No charge, deductible does not apply | Not Covered | 30 days/calendar year. Preauthorization is required or services not covered. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Durable medical equipment | No charge, deductible does not apply | Not Covered | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | No charge, deductible does not apply | Not Covered | Preauthorization is not required. Please notify Molina before services are rendered. |
| If your child needs dental or eye care | Children's eye exam | No charge, deductible does not apply | Not Covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge, deductible does not apply | Not Covered | Coverage limited to one pair of glasses/year. |
| | 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) <br> • Acupuncture <br> • Bariatric surgery <br> • Cosmetic surgery | • Dental care (Adult) <br> • Hearing aids <br> • Infertility treatment <br> • Long-term care | • Non-emergency care when traveling outside the U.S. <br> • Private-duty nursing <br> • Routine eye care (Adult) <br> • 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 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: 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 **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 | Managing Joe's Type 2 Diabetes | Mia's Simple Fracture |
|---|---|---|
| (9 months of in-network pre-natal care and a hospital delivery) | (a year of routine in-network care of a well-controlled condition) | (in-network emergency room visit and follow up care) |

| Peg | | Joe | | Mia | |
|---|---|---|---|---|---|
| ■ The plan's overall deductible | $0 | ■ The plan's overall deductible | $0 | ■ The plan's overall deductible | $0 |
| ■ Specialist Copayment | $0 | ■ Specialist Copayment | $0 | ■ Specialist Copayment | $0 |
| ■ Hospital (facility) Coinsurance | 0% | ■ Hospital (facility) Coinsurance | 0% | ■ Hospital (facility) Coinsurance | 0% |
| ■ Other Coinsurance | 0% | ■ Other Coinsurance | 0% | ■ Other Coinsurance | 0% |

**This EXAMPLE event includes services like:**

| | | |
|---|---|---|
| Specialist office visits (prenatal care) | Primary care physician office visits (including disease education) | Emergency room care (including medical supplies) |
| Childbirth/Delivery Professional Services | Diagnostic tests (blood work) | Diagnostic test (x-ray) |
| Childbirth/Delivery Facility Services | Prescription drugs | Durable medical equipment (crutches) |
| Diagnostic tests (ultrasounds and blood work) | Durable medical equipment (glucose meter) | Rehabilitation services (physical therapy) |
| Specialist visit (anesthesia) | | |

| Total Example Cost | $12,700 | Total Example Cost | $5,600 | Total Example Cost | $2,800 |
|---|---|---|---|---|---|

**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** |

**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** |

**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.

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) 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 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

| | |
|---|---|
| English | For free language assistance services, and auxiliary aids and services, call 1-866-472-9484 (TTY: 711). |
| Spanish<br>Español | Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-866-472-9484 (TTY: 711). |
| Vietnamese<br>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 (Traditional)<br>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 1-866-472-9484（聽障專線：711）。 |
| French<br>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<br>العربية | اتصل عل الرقم 9484-472-866-1 (الهاتف النص 711 :(TTY)) لتليق خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية. |
| Choctaw<br>Chahta | Áyanohollo vlla anompoli ish aihvlạkvta, ik aiittvnaha anompoli ish aihvlạkvta il haklo ma 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<br>Deutsch | Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-866-472-9484 (TTY: 711). |
| Korean<br>한국인 | 무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-866-472-9484 (TTY: 711)로 연락 주시기 바랍니다. |
| Gujarati<br>ગુજરાતી | મફત ભાષા સહયોગ સેવાઓ અને સહાયક સાધનો તથા સેવાઓ માટે 1-866-472-9484 (TTY: 711) પર કોલ કરો. |
| 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、1-866-472-9484（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: 1-866-472-9484 (телетайп: 711). |
| Panjabi<br>ਪੰਜਾਬੀ | ਮੁਫ਼ਤ ਭਾਸਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਅਤੇ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ, 1-866-472-9484 (TTY: 711) ਤੇ ਕਾਲ ਕਰੋ। |
| Italian<br>Italiano | Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-866-472-9484 (TTY: 711). |
| Hindi<br>हिंदी | निःशुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-866-472-9484 (TTY: 711) पर कॉल करें। |