




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 1-866-472-9484. 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](https://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 <a href="#">deductible</a> ?	\$6,000/Individual or \$12,000/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and services indicated in the chart starting on page 2.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$8,900 individual / \$17,800 family; for <a href="#">out-of-network providers</a> there is no coverage unless Prior Authorized by Molina Healthcare.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See MolinaMarketplace.com or call 1-866-472-9484 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <a href="#">Copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	\$80 <a href="#">Copay</a> , <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening</a> /immunization	No charge, <a href="#">deductible</a> does not apply	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a> for blood work 40% <a href="#">Coinsurance</a> after <a href="#">deductible</a> /test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://MolinaMarketplace.com/MSFormulary2026">http://MolinaMarketplace.com/MSFormulary2026</a>	Generic drugs - preferred	\$20 <a href="#">Copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered. For brand name drugs with a generic equivalent, coupons or any other form of third-party <a href="#">prescription drug</a> cost sharing assistance will not apply toward any <a href="#">deductibles</a> or annual <a href="#">out-of-pocket limits</a> .
	Preferred brand drugs	\$40 <a href="#">Copay</a> /prescription, <a href="#">deductible</a> does not apply	Not Covered	
	Non-preferred brand drugs and non-preferred generic drugs	\$80 <a href="#">Copay</a> after <a href="#">deductible</a> / prescription	Not Covered	
	<a href="#">Specialty drugs</a>	\$350 <a href="#">Copay</a> after <a href="#">deductible</a> / prescription	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered. Mail order not available.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> 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)	
	Physician/surgeon fees	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	<a href="#">Emergency room care coinsurance</a> does not apply, if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$60 <a href="#">Copay</a> , <a href="#">deductible</a> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required or services not covered.
	Physician/surgeon fees	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">Copay</a> /visit, <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is required for inpatient care or services not covered.
	Inpatient services	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Cost sharing</a> does not apply to routine prenatal care and first post-natal visit and certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	Services must be provided by an in network Home health agency.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">Copay</a> /visit, <a href="#">deductible</a> 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 <a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Habilitation services</a>	\$40 <a href="#">Copay</a> /visit,	Not Covered	<a href="#">Preauthorization</a> may be required, or

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)	
		<a href="#">deductible</a> does not apply		services not covered.
	<a href="#">Skilled nursing care</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	30 days/calendar year. <a href="#">Preauthorization</a> is required or services not covered.
	<a href="#">Durable medical equipment</a>	40% <a href="#">Coinsurance</a> after <a href="#">deductible</a>	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is not required. Please notify Molina before services are rendered.
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply	Not Covered	Coverage limited to one exam/year.
	Children's glasses	No charge, <a href="#">deductible</a> 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 <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>Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</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>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</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: 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](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: 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

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist Copayment</a>	\$80
■ Hospital (facility) <a href="#">Coinsurance</a>	40%
■ Other <a href="#">Coinsurance</a>	40%

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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$6,000
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$2,600
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$8,670</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist Copayment</a>	\$80
■ Hospital (facility) <a href="#">Coinsurance</a>	40%
■ Other <a href="#">Coinsurance</a>	40%

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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,100</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,000
■ <a href="#">Specialist Copayment</a>	\$80
■ Hospital (facility) <a href="#">Coinsurance</a>	40%
■ Other <a href="#">Coinsurance</a>	40%

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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,700
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,100</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.