The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit our website at MolinaMarketplace.com or call 1-888-295-7651. For 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?	$1,550 / individual or $3,100 / family Combined Medical and Rx	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, PCP and Specialist office visits, pediatric vision, Urgent Care, Rehab., Hab.,Hospice, mental health, behavioral health, or substance abuse services, preventive and generic prescription drugs. Testing, vaccination and delivery of healthcare services related to COVID-19.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,100 / individual or $16,200 /family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See Molina Marketplace Network at providersearch.Molinahealthcare.com or call 1-888-295-7651 for a list of network providers.	This plan uses a network provider. 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.

Please Note: There is no charge for testing and delivery of healthcare services related to COVID-19.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay /visit; deductible does not apply	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider.
	Specialist visit	$50 copay /visit; deductible does not apply	Not covered	Preauthorization may be required or services may not be covered. You may be subject to additional facility/clinic fees. Please check with your
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Including artery calcification testing for heart disease. Testing, vaccination and delivery of healthcare services related to COVID-19 are at No Charge. You may be subject to additional facility/clinic fees. Please check with
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay ; deductible does not apply /test for blood work; 25% coinsurance /test for x-rays	Not covered	Testing, vaccination and delivery of healthcare services related to COVID-19 are at No Charge. You may be subject to additional facility/clinic fees. Please check with your provider.
	Imaging (CT/PET scans, MRIs)	25% coinsurance /test	Not covered	Preauthorization may be required or services may not be covered. For gynecological or obstetrical ultrasounds, preauthorization is not required. You may be subject to additional facility/clinic fees. Please check with your provider.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs	$15 copay (retail); deductible does not apply	Not covered	Preauthorization may be required or services may not be covered. Mail-order Prescription Drugs are available at a 90-day supply and is offered at three times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance. Insulin or a medically necessary alternative will not exceed a total of twenty-five dollars($25.00) per thirty-day supply. Behavioral Health, or Substance Abuse
	Preferred brand drugs	$50 copay (retail)	Not covered	

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
http://www.molinamarketplace.com/NMFormulary2025	Non-preferred brand drugs	28% coinsurance (retail)	Not covered	drugs subject to Senate Bill 317 are at No Charge. Preventive Care and Contraceptive Drugs are at No Charge. We accept cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon) and that the rebated amount will count towards the member's cost-sharing. Testing, vaccination and delivery of healthcare services related to COVID-19 are at No Charge.
	Specialty drugs	Preferred Specialty: 25% coinsurance ; Non-Preferred Specialty 30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	Preauthorization may be required or services may not be covered.
	Physician/surgeon fees	25% coinsurance	Not covered	Preauthorization may be required or services may not be covered. Laser corrective eye surgery is not covered. You may be subject to additional facility/clinic fees. Please check with your provider.
If you need immediate medical attention	Emergency room care	25% coinsurance /visit; deductible does not apply	25% coinsurance /visit; deductible does not apply	Emergency room care copay does not apply, if admitted to the hospital. Amounts you pay, such as deductible, copayments or coinsurance, for emergency services whether provided by contracted or non-contracted providers are applied to your out-of-pocket limit. Balance billing is not allowed for out-of-network care. You may be subject to additional facility/clinic fees. Please check with your provider.
	Emergency medical transportation	25% coinsurance	25% coinsurance	
	Urgent care	$20 copay; deductible does not apply	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider.

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

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not covered	Preauthorization is required or services may not be covered.
	Physician/surgeon fees	25% coinsurance	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge /office visit and Outpatient Intensive Psychiatric Treatment Programs No Charge	Not covered	Preauthorization is required for inpatient care or services may not be covered. You may be subject to additional facility/clinic fees. Please check with your provider.
	Inpatient services	No Charge	Not covered	
If you are pregnant	Office visits	No charge	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. Preauthorization is not required for maternity ultrasounds. You may be subject to additional facility/clinic fees. Please check with your provider.
	Childbirth/delivery professional services	25% coinsurance /visit	Not covered	
	Childbirth/delivery facility services	25% coinsurance	Not covered	
If you need help recovering or have other special needs	Home health care	No charge	Not covered	100 visits/year. Services must be provided by an in network Home health agency.
	Rehabilitation services	$20 copay/visit; deductible does not apply	Not covered	Preauthorization is required for inpatient care or services may not be covered. Visit limit does not apply. You may be subject to additional facility/clinic fees. Please check with your provider.

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
	Habilitation services	$20 copay/visit; deductible does not apply	Not covered	Preauthorization is required for inpatient care or services may not be covered. Visit limit does not apply. You may be subject to additional facility/clinic fees. Please check with your provider.
	Skilled nursing care	25% coinsurance	Not covered	60 days/calendar year. Preauthorization is required or services may not be covered. You may be subject to additional facility/clinic fees. Please check with your provider.
	Durable medical equipment	25% coinsurance	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	$50 copay; deductible does not apply	Not covered	You may be subject to additional facility/clinic fees. Please check with your provider.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam including refraction/year.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental checkups	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)
- Cosmetic Surgery
- Dental Care (Adult, routine dental)
- Long-Term Care
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care (Routine foot care items and services are not covered, except for Members with diabetes unless medically necessary due to diabetes or other significant peripheral neuropathies.)
- Weight Loss Programs (unless for dietary evaluation and counseling for medical management of morbid obesity and obesity are covered)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 20 visits per year, unless for rehabilitative or habilitative purposes) • Bariatric Surgery	• Chiropractic Care (up to 20 visits per year, unless for rehabilitative or habilitative purposes) • Hearing Aids (one hearing aid per ear every 36 months)	• Infertility (limited to diagnosis and medically indicated treatments for physical conditions causing infertility)

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: New Mexico Office of Superintendent of Insurance 1 (833) 415-0566 or www.osi.state.nm.us, and beWellnm 1 (833) 862-3925 or www.beWellnm.com. 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: Molina Healthcare of New Mexico at 1 (888) 295-7651 or the Office of Superintendent of Insurance, Managed Health Care Bureau at 1-833-415-0566) or mhcb.grievance@state.nm.us.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 295-7651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1 (888) 295-7651.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1 (888) 295-7651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (888) 295-7651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,550
Specialist Copayment	$50
Hospital (facility) coinsurance after ded.	25%
Other coinsurance after ded	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*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$300
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,350**

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

The plan's overall deductible	$1,550
Specialist Copayment	$50
Hospital (facility) coinsurance after ded.	25%
Other coinsurance after ded	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*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,550**

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

The plan's overall deductible	$1,550
Specialist Copayment	$50
Hospital (facility) coinsurance after ded.	25%
Other coinsurance after ded	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*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$200
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,790**

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 1-888-295-7651 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

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 1-888-295-7651 (TTY: 711).
Spanish Español	Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-295-7651 (TTY: 711).
Navajo Diné	T'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í, dóó bee ahxił hane'í ádaat'éhígíí dóó bee áka'nída'awo'í biniiyégo, kohjį' hodíilnih 1-888-295-7651 (TYY: 711).
Vietnamese Tiếng Việt	Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm, hãy gọi 1-888-295-7651 (TTY: 711).
German Deutsch	Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-295-7651 (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1-888-295-7651（TTY 用户请拨打 711）。
Arabic العربية	اتصل على الرقم 1-888-295-7651 (الهاتف النصي (TTY): 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면1-888-295-7651 (TTY: 711)로 연락 주시기 바랍니다.
Tagalog	Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-295-7651 (TTY: 711).

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、1-888-295-7651（TTY: 711）までお電話ください。
French Français	Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-295-7651 (ATS : 711).
Italian Italiano	Per i servizi di assistenza gratuiti in italiano nonché per supporti e servizi ausiliari, chiamare 1-888-295-7651 (TTY: 711).
Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-295-7651 (телетайп: 711).
Hindi हिंदी	नि:शुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-888-295-7651 (TTY: 711) पर कॉल करें।
Persian فارسی	برای دریافت خدمات کمک زبانی رایگان، و کمک‌ها و خدمات اضافی با این شماره تماس بگیرید: 1-888-295-7651 (TTY: 711).
Thai ไทย	ความสนใจ:สำหรับบริการช่วยเหลือฟรีด้านภาษาและบริการเสริม โปรดโทร 1-888-295-7651 (TTY: 711).