


**⚠ 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](http://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](http://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>	\$3,000 / individual or \$6,000 / family Combined Medical and Rx	Generally, you must pay all of the costs from providers 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. All covered services except ER room, Inpatient services, and Non-preferred brand <a href="#">prescription drugs</a> . Testing, vaccination, and delivery of healthcare services related to COVID-19	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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$6,000 / individual or \$12,000 /family	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.
<b>What is not included in the out-of-pocket limit?</b>	<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> .
<b>Will you pay less if you use a network provider?</b>	Yes. See Molina Marketplace Network at <a href="http://MolinaMarketplace.com/NMFindCare">MolinaMarketplace.com/NMFindCare</a> or call 1-888-295-7651 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">network provider</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.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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.

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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	Other practitioner office visits are at the same cost share as primary care. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required or services may not be covered. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Including artery calcification testing for heart disease. No cost sharing for COVID testing and treatment. You may be subject to additional facility/clinic fees. Please check with your provider.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$60 <a href="#">copay, deductible</a> does not apply_/test for blood work; \$60 <a href="#">copay, deductible</a> does not apply_/test for x-rays	Not Covered	No cost sharing for COVID testing and treatment. You may be subject to additional facility/clinic fees. Please check with your provider.
	Imaging (CT/PET scans, MRIs)	\$60 <a href="#">copay</a> /test; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required or services may not be covered. No <a href="#">Preauthorization</a> for gynecological or obstetrical ultrasounds. You may be subject to additional facility/clinic fees. Please check with your provider.
<b>If you need drugs to treat your illness or condition</b> <b>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.molina">http://www.molina</a></b>	Generic drugs	\$20 <a href="#">copay</a> (retail); <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required or services may not be covered. Mail-order <a href="#">Prescription Drugs</a> are available at a 90-day supply and is offered at three times the 30-day retail prescription <a href="#">Cost Sharing</a> . Depending on Tier level this will be either a <a href="#">Copayment</a> or a <a href="#">Coinsurance</a> . 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 drugs
	Preferred brand drugs	\$30 <a href="#">copay</a> (retail); <a href="#">deductible</a> does not apply	Not Covered	
	Non-preferred brand drugs	\$100 <a href="#">copay</a> ;with <a href="#">deductible</a> (retail)	Not Covered	
	<a href="#">Specialty drugs</a>	Preferred: \$75 <a href="#">copay</a> (retail) ; <a href="#">deductible</a> does not apply, Non-Preferred: \$190 <a href="#">copay</a> (retail) ; <a href="#">deductible</a> does not apply	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.MolinaMarketplace.com](http://www.MolinaMarketplace.com)

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="https://marketplace.com/NMFormulary2026.com">marketplace.com/ NMFormulary2026 .com</a>				subject to state law are at No Charge. Preventive Care and Contraceptive Drugs are at No Charge. We accept <a href="#">Cost sharing</a> accumulation for any third-party payment (such as a drug manufacturer's coupon) and the rebated amount will count towards the member's cost-sharing. No cost sharing for COVID testing and treatment .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$125 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required or services may not be covered.
	Physician/surgeon fees	\$125 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> 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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> with <a href="#">deductible</a> /visit	\$150 <a href="#">copay</a> with <a href="#">deductible</a> /visit	<a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital. Amounts you pay, such as <a href="#">deductible</a> , <a href="#">copayments</a> or <a href="#">coinsurance</a> , for emergency services whether provided by contracted or non-contracted providers are applied to your <a href="#">out-of-pocket limit</a> . You may be subject to additional facility/clinic fees. Please check with your provider. Balance billing is not allowed for out-of-network services. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Emergency medical transportation</a>	\$125 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	\$125 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	
	<a href="#">Urgent care</a>	\$ 60 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 <a href="#">copay</a> with <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required or services may not be covered.
	Physician/surgeon fees	\$150 <a href="#">copay</a> with <a href="#">deductible</a>	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider.

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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No Charge /office visit and Outpatient Intensive Psychiatric Treatment Programs No Charge	Not Covered	<a href="#">Preauthorization</a> 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	
<b>If you are pregnant</b>	Office visits	No Charge	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. <a href="#">Preauthorization</a> is not required for maternity ultrasounds. You may be subject to additional facility/clinic fees. Please check with your provider.
	Childbirth/delivery professional services	\$150 <a href="#">copay</a> with <a href="#">deductible</a> /visit	Not Covered	
	Childbirth/delivery facility services	\$150 <a href="#">copay</a> with <a href="#">deductible</a>	Not Covered	
<b>If you need help recovering or have other special needs</b>	<a href="#">Home health care</a>	\$20 <a href="#">copay</a> /per day; <a href="#">deductible</a> does not apply	Not Covered	100 visits/year. Services must be provided by an in network Home health agency. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Rehabilitation services</a>	\$20 <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 may not be covered. Visit limit does not apply. <a href="#">Cost sharing</a> for physical therapy does not exceed cost-sharing for PCP visits. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Habilitation services</a>	\$20 <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 may not be covered. Visit limit does not apply. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Skilled nursing care</a>	\$60 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	60 days/calendar year. <a href="#">Preauthorization</a> is required or services may not be covered. You may be subject to additional facility/clinic fees. Please check with your provider.
	<a href="#">Durable medical equipment</a>	\$60 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom

\* For more information about limitations and exceptions, see the plan or policy document at [www.MolinaMarketplace.com](http://www.MolinaMarketplace.com)

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)	
				equipment.
	<a href="#">Hospice services</a>	\$60 <a href="#">copay</a> /per day; <a href="#">deductible</a> does not apply	Not Covered	You may be subject to additional facility/clinic fees. Please check with your provider.
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Dental Care (Adult, routine dental)</li><li>• Infertility (except for services limited to diagnosis and medically indicated treatments for physical conditions causing infertility)</li></ul>	<ul style="list-style-type: none"><li>• Long-Term Care</li><li>• Non-emergency care when traveling outside the U.S</li><li>• Private Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• 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. )</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Abortion ( in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture (up to 20 visits per year, unless for rehabilitative or habilitative purposes)</li></ul>	<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care (up to 20 visits per year, unless for rehabilitative or habilitative purposes)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids (one hearing aid per ear every 36 months)</li><li>• Infertility (limited to diagnosis and medically indicated treatments for physical conditions causing infertility)</li><li>• Weight Loss Programs (for dietary evaluation and counseling for medical management of morbid obesity and obesity are covered)</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: New Mexico Office of Superintendent of Insurance 1 (833) 415-0566 or [www.osi.state.nm.us](http://www.osi.state.nm.us), and beWellnm 1 (833) 862-3925 or [www.beWellnm.com](http://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](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: 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](mailto: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, kwijigo 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](#) \$3,000
- [Specialist Copayment](#) \$60
- Hospital (facility) [copay](#) after [ded.](#) \$150
- Other [copay](#) after [ded](#) \$150

#### 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:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$1,000
Coinsurance	\$0

#### *What isn't covered*

Limits or exclusions	\$0
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<b>The total Peg would pay is</b>	<b>\$4,000</b>
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### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist Copayment](#) \$60
- Hospital (facility) [copay](#) after [ded.](#) \$150
- Other [copay](#) after [ded](#) \$150

#### 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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,700
Coinsurance	\$0

#### *What isn't covered*

Limits or exclusions	\$0
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<b>The total Joe would pay is</b>	<b>\$1,700</b>
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist Copayment](#) \$60
- Hospital (facility) [copay](#) after [ded.](#) \$150
- Other [copay](#) after [ded](#) \$150

#### 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:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$800
Coinsurance	\$0

#### *What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,200</b>
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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](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



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

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, dóo bee ahxil hane'í ádaat'éhígíí dóo bee áka'nída'awo'í biniyégo, kohj'í hodíilnih 1-888-295-7651 (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 1-888-295-7651 (TTY: 711).
German Deutsch	Kostenlose Sprachassistenzen, 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 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.
Korean 한국인	무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-888-295-7651 (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).



Notice of Availability – Section 1557  
Molina Healthcare - Marketplace

Russian Русский	Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-295-7651 (телетайп: 711).
Hindi हिंदी	निःशुल्क 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).