



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 (855) 885-3176. 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 [healthcare.gov/sbc-glossary/](https://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 <u>deductible</u>?</b>                             | \$1,425/Individual or \$2,850/Family   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. <u>Preventive care</u> and services indicated in the chart starting on page 2.  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | For <u>network providers</u> \$3,050 individual / \$6,100 family; for <u>out-of-network providers</u> , there is no coverage unless Prior Authorized by Molina Healthcare. | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See MolinaMarketplace.com or call 1 (855) 885-3176 for a list of <u>network providers</u> .   | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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's charge</u> 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.  | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |

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   |
|---|---|---|---|--|
|   |   | Participating Provider<br>(You will pay the least)                | Non-Participating Provider<br>(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          | \$10 <u>copay</u> /visit, <u>deductible</u> does not apply        | Not covered   | No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse.  |
|   | <u>Specialist</u> visit                                   | \$15 <u>copay</u> /visit, <u>deductible</u> does not apply        | Not covered   | <u>Preauthorization</u> may be required, or services not covered.  |
|   | <u>Preventive care/screening/immunization</u>             | No charge, <u>deductible</u> does not apply                       | Not covered   | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>   | <u>Diagnostic test</u> (x-ray, blood work)                | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   | None   |
|   | Imaging (CT/PET scans, MRIs)                              | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   | <u>Preauthorization</u> is required or Imaging services are not covered  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="https://MolinaMarketplace.com/SCFormulary2025">MolinaMarketplace.com/SCFormulary2025</a> | Generic drugs - preferred                                 | \$5 <u>copay</u> /prescription, <u>deductible</u> does not apply  | Not covered   | <u>Preauthorization</u> may be required, or services may be not covered.<br>Up to 30-day supply retail. For tiers 1, 2 and 3, up to 90-day supply by mail order offered at three times the 30-day retail <u>cost-sharing</u> .<br>For brand drugs with a generic equivalent, coupons or any other form of third-party prescription drug <u>cost-sharing</u> assistance will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limit</u> . |
|   | Preferred brand drugs                                     | \$50 <u>copay</u> /prescription, <u>deductible</u> does not apply | Not covered   |  |
|   | Non-preferred brand drugs and non-preferred generic drugs | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   |  |
|   | <u>Specialty drugs</u>                                    | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)            | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   | <u>Preauthorization</u> may be required, or services not covered.  |
|   | Physician/surgeon fees                                    | 20% <u>coinsurance</u> after <u>deductible</u>                    | Not covered   | <u>Preauthorization</u> may be required, or services not covered.  |
| <b>If you need immediate medical attention</b>  | <u>Emergency room care</u>                                | 20% <u>coinsurance</u> after <u>deductible</u>                    | 20% <u>coinsurance</u> after <u>deductible</u>        | <u>Cost-sharing</u> for <u>emergency room care</u> does not apply if admitted to the hospital.   |
|   | <u>Emergency medical transportation</u>                   | 20% <u>coinsurance</u> after <u>deductible</u>                    | 20% <u>coinsurance</u> after <u>deductible</u>        |  |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|
|   |   | Participating Provider<br>(You will pay the least)         | Non-Participating Provider<br>(You will pay the most) |   |
|   | <u>Urgent care</u>                        | \$13 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered   |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   | <u>Preauthorization</u> is required or services not covered.  |
|   | Physician/surgeon fees                    | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$10 <u>copay</u> /visit, <u>deductible</u> does not apply | Not covered   | No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse.<br><u>Preauthorization</u> is required for inpatient care or services not covered.                        |
|   | Inpatient services                        | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   |   |
| If you are pregnant   | Office visits                             | No charge, <u>deductible</u> does not apply                | Not covered   | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   |   |
|   | Childbirth/delivery facility services     | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   |   |
| If you need help recovering or have other special health needs            | <u>Home health care</u>                   | No charge, <u>deductible</u> does not apply                | Not covered   | Limited to 60 visits per calendar year. Services must be provided by an in-network home health agency. <u>Preauthorization</u> may be required, or services may be not covered.   |
|   | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   | Physical therapy, speech therapy, and occupational therapy limited to 30 visits per therapy type per year. <u>Preauthorization</u> may be required, or services may be not covered.   |
|   | <u>Habilitation services</u>              | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   | <u>Preauthorization</u> may be required, or services not covered.   |
|   | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   | Limited to 60 days per calendar year. <u>Preauthorization</u> is required, or services may be not covered   |
|   | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u> after <u>deductible</u>             | Not covered   | Prior authorization may be required, or services may be not covered.  |

| Common Medical Event                          | Services You May Need      | What You Will Pay                                  |   | Limitations, Exceptions, & Other Important Information  |
|---|----------------------------|--|---|---|
|   |                            | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |   |
|   | <u>Hospice services</u>    | No charge, <u>deductible</u> does not apply        | Not covered   | <u>Preauthorization</u> is not required. Please notify Molina before services are rendered.   |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | No charge, <u>deductible</u> does not apply        | Not covered   | One screening/exam per calendar year  |
|   | Children's glasses         | No charge, <u>deductible</u> does not apply        | Not covered   | Coverage limited to one pair of glasses (lenses and frames) or contact lenses in lieu of prescription glasses/year. Laser corrective surgery not covered. |
|   | Children's dental check-up | Not covered  | Not covered   | None  |

## 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>• Routine foot care</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>• Weight loss programs</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: South Carolina Department of Insurance 1 (800) 768-3467. 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: South Carolina Department of Insurance 1 (800) 768-3467.

### 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? Not Applicable.

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 <u>plan's</u> overall <u>deductible</u> | \$1,425 |
| ■ <u>Specialist copayment</u>                 | \$15    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,400        |
| <u>Copayments</u>                 | \$20           |
| <u>Coinsurance</u>                | \$1,600        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,020</b> |

### 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> | \$1,425 |
| ■ <u>Specialist copayment</u>                 | \$15    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$900          |
| <u>Copayments</u>                 | \$900          |
| <u>Coinsurance</u>                | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,800</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,425 |
| ■ <u>Specialist copayment</u>                 | \$15    |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%     |
| ■ Other <u>coinsurance</u>                    | 20%     |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,400        |
| <u>Copayments</u>                 | \$50           |
| <u>Coinsurance</u>                | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,550</b> |

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 1-855-885-3176 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  
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>



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|--------------------------|--|
| English                  | For free language assistance services, and auxiliary aids and services, call 1-855-885-3176 (TTY: 711).  |
| Spanish<br>Español       | Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-855-885-3176 (TTY: 711).                |
| Chinese<br>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1-855-885-3176 (TTY 用户请拨打 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 1-855-885-3176 (TTY: 711).                          |
| Korean<br>한국인            | 무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-855-885-3176 (TTY: 711)로 연락 주시기 바랍니다.  |
| French<br>Français       | Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-855-885-3176 (ATS : 711). |
| Tagalog                  | Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-855-885-3176 (TTY: 711).                                    |
| Russian<br>Русский       | Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-855-885-3176 (телетайп: 711).                    |
| German<br>Deutsch        | Kostenlose Sprachassistenzen, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-855-885-3176 (TTY: 711).   |
| Gujarati<br>ગુજરાતી      | મફત ભાષા સહયોગ સેવાઓ અને સહાયક સાધનો તથા સેવાઓ માટે 1-855-885-3176 (TTY: 711) પર કોલ કરો.  |
| Arabic<br>العربية        | اتصل على الرقم 1-855-885-3176 (الهاتف النصي 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية.                                   |
| Portuguese<br>Português  | Para obter serviços de assistência linguística e materiais e serviços auxiliares gratuitos ligue para 1-855-885-3176 (telefone de texto [TTY]: 711).   |



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|------------------------------|--|
| 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、1-855-885-3176 ( TTY: 711 ) までお電話ください。  |
| Ukrainian<br>Українська      | Для отримання безкоштовної мовної допомоги, допоміжних засобів та послуг телефонуйте за номером 1-855-885-3176 (TTY: 711). |
| Hindi<br>हिंदी               | निःशुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-855-885-3176 (TTY: 711) पर कॉल करें।                           |
| Mon-Khmer Cambodian<br>ខ្មែរ | សម្រាប់សេវាកម្មជំនួយភាសា និងជំនួយផ្នែកស្តាប់ដោយឥតគិតថ្លៃ សូមទូរសព្ទទៅ 1-855-885-3176 (TTY: 711)។                           |