
 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, [www.molinamarketplace.com/marketplace/tx/en-us/MemberForms.aspx](http://www.molinamarketplace.com/marketplace/tx/en-us/MemberForms.aspx). 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](http://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> ?                                | \$2,500 / individual or \$5,000 / 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. Covered medical services listed without deductible and Formulary Generic, Preferred Brand, and Preventive <a href="#">prescription drug</a> are covered before you meet your <a href="#">deductible</a> . | 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?              | Yes. \$2,500 Individual or \$5,000/family for <a href="#">prescription drug coverage</a> .   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,100 Individual or \$18,200/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.   |
| 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 <a href="http://MolinaMarketplace.com">MolinaMarketplace.com</a> or call 1-888-858-3492 for a list of participating providers.  | 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.

| What You Will Pay  |   |  |  |  |
|--|---|--|--|--|
| Common Medical Event   | Services You May Need   | Participating Provider<br>(You will pay the least)   | Non-Participating<br>Provider<br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information*   |
| If you visit a health care<br><a href="#">provider's</a> office or clinic  | Primary care visit to treat<br>an injury or illness             | \$30 <a href="#">copay</a> /office visit   | Not covered  | None   |
|  | <a href="#">Specialist</a> visit                                | \$60 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> may be required, or services<br>not covered.  |
|  | <a href="#">Preventive<br/>care/screening/<br/>immunization</a> | No Charge  | Not covered  | You may have to pay for services that aren't<br>preventive. Ask your <a href="#">provider</a> if the services<br>needed are preventive. Then check what your<br><a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray,<br>blood work)          | \$60 <a href="#">copay</a> /test for blood work<br>\$95 per test for x- rays   | Not covered  | None   |
|  | Imaging (CT/PET<br>scans, MRIs)                                 | 50% <a href="#">copayment</a> after<br><a href="#">deductible</a>  | Not covered  | <a href="#">Preauthorization</a> is required or Imaging services<br>are not covered.   |
| If you need drugs to<br>treat your illness or<br>condition<br>More information<br>about <a href="#">prescription<br/>drug coverage</a> is<br>available at <a href="#">MolinaMarketplace.co<br/>m/TXFormulary2023</a> | Generic drugs   | \$29 <a href="#">copay</a> /prescription<br><a href="#">deductible</a> does not apply<br>(retail); \$72.50 cost share for<br>90 day supply <a href="#">deductible</a><br>does not apply (mail) | Not covered  | <a href="#">Preauthorization</a> may be required or services<br>may not be covered. Mail-order <a href="#">Prescription<br/>Drugs</a> are available at a 90-day supply and is<br>offered at two-and-a-half times the 30-day retail<br>prescription <a href="#">Cost Sharing</a> . Depending on Tier<br>level this will be either a <a href="#">Copayment</a> or a<br><a href="#">Coinsurance</a> |
|  | Preferred brand drugs   | \$60 <a href="#">copay</a> /prescription<br><a href="#">deductible</a> does not apply<br>(retail); \$150 cost share for<br>90 day supply <a href="#">deductible</a><br>does not apply (mail)   | Not covered  |  |
|  | Non-preferred brand drugs                                       | 50% <a href="#">copayment</a> after<br><a href="#">deductible</a> (retail); 2.5x cost<br>share of 50% after <a href="#">deductible</a><br>for 90 day supply (mail)                             | Not covered  |  |
|  | <a href="#">Specialty drugs</a>                                 | 50% <a href="#">copayment</a> after<br><a href="#">deductible</a>  | Not covered  |  |

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

| What You Will Pay   |  |  |  |  |
|---|--|--|--|--|
| Common Medical Event  | Services You May Need                            | Participating Provider<br>(You will pay the least)   | Non-Participating<br>Provider<br>(You will pay the most)       | Limitations, Exceptions, & Other<br>Important Information*   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 50% <a href="#">copayment</a> after <a href="#">deductible</a>   | Not covered  | <a href="#">Preauthorization</a> may be required, or services not covered.   |
|   | Physician/surgeon fees                           | 50% <a href="#">copayment</a> after <a href="#">deductible</a>   | Not covered  | <a href="#">Preauthorization</a> may be required, or services not covered. Laser corrective eye surgery is not covered.  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$950 <a href="#">copay</a> per visit  | \$950 <a href="#">copay</a> per visit                          | <a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital.   |
|   | <a href="#">Emergency medical transportation</a> | 50% <a href="#">copayment</a> after <a href="#">deductible</a>   | 50% <a href="#">copayment</a> after <a href="#">deductible</a> | None   |
|   | <a href="#">Urgent care</a>                      | \$30 <a href="#">copay</a> /visit  | Not covered  | None   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | \$1,200 <a href="#">copay</a> per day (maximum of 2 days)  | Not covered  | <a href="#">Preauthorization</a> is required or services not covered.  |
|   | Physician/surgeon fees                           | \$60 <a href="#">copay</a> /visit  | Not covered  | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copay</a> /office visit<br>Outpatient Intensive Psychiatric Treatment Programs - 50% <a href="#">copayment</a> after <a href="#">deductible</a> per day (maximum of 2 days) | Not covered  | <a href="#">Preauthorization</a> is required for Electroconvulsive Therapy (ECT), neuropsychological and psychological testing, partial <a href="#">hospitalization</a> , behavioral health treatment for PDD/autism, substance abuse services, Day Treatment, detoxification services and inpatient care or services not covered. |
|   | Inpatient services                               | \$1,200 <a href="#">copay</a> per day (maximum of 2 days)  | Not covered  |  |

| What You Will Pay                                       |   |  |  |   |
|---|---|--|--|---|
| Common Medical Event                                    | Services You May Need                     | Participating Provider<br>(You will pay the least)             | Non-Participating<br>Provider<br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information*  |
| If you are pregnant                                     | 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 elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services | \$60 <a href="#">copay</a> /visit                              | Not covered  |   |
|   | Childbirth/delivery facility services     | \$1,200 <a href="#">copay</a> per day (maximum of 2 days)      | Not covered  |   |
| If you need help recovering or have other special needs | <a href="#">Home health care</a>          | No Charge  | Not covered  | 60 visits/year. Services must be provided by an in <a href="#">network</a> Home health agency.  |
|   | <a href="#">Rehabilitation services</a>   | \$60 <a href="#">copay</a> /visit                              | Not covered  | 35 visits/year. <a href="#">Medically necessary</a> services only. <a href="#">Preauthorization</a> is required for Occupational Therapy, Speech Therapy, Physical Therapy, Radiation therapy and radio surgery <a href="#">Rehabilitation services</a> or services not covered.  |
|   | <a href="#">Habilitation services</a>     | \$60 <a href="#">copay</a> /visit                              | Not covered  | 35 visits/year. Does not apply to MH/SUD conditions.  |
|   | <a href="#">Skilled nursing care</a>      | \$1,200 <a href="#">copay</a> per day                          | Not covered  | 25 days/calendar year. <a href="#">Preauthorization</a> is required or services not covered.  |
|   | <a href="#">Durable medical equipment</a> | 50% <a href="#">copayment</a> after <a href="#">deductible</a> | Not covered  | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> may be required or services not covered  |
|   | <a href="#">Hospice services</a>          | No Charge  | Not covered  | None  |
|   |   |  |  |   |
| If your child needs dental or eye care                  | Children's eye exam                       | No Charge  | Not covered  | Coverage limited to one exam/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.  |

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

## Excluded Services & Other Covered Services

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                       |  |  |
|---|--|--|
| <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>• Dental Care (Child)</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>• Routine Foot Care</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 <a href="#">plan</a> document.)  |  |  |
| <ul style="list-style-type: none"><li>• Chiropractic Care (related to Rehabilitation benefits, combined 35 visit limit)</li></ul>   | <ul style="list-style-type: none"><li>• Hearing Aids (1 hearing aid every 36 months)</li></ul>   | <ul style="list-style-type: none"><li>• <a href="#">Private Duty Nursing</a> (Medically Necessary)</li><li>• Routine eye care (Adult)</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 Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439. 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 Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439.

### 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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-560-2025.


Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-560-2025 .

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-560-2025.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-560-2025.

*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> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$1,200 |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a>           | \$0            |
| <a href="#">Copayments</a>            | \$2,100        |
| Percentage <a href="#">Copayments</a> | \$0            |
| What isn't covered                    |                |
| Limits or exclusions                  | \$0            |
| <b>The total Peg would pay is</b>     | <b>\$2,100</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> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$1,200 |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a>           | \$800          |
| <a href="#">Copayments</a>            | \$1,400        |
| Percentage <a href="#">Copayments</a> | \$0            |
| What isn't covered                    |                |
| Limits or exclusions                  | \$0            |
| <b>The total Joe would pay is</b>     | <b>\$2,200</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> | \$2,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$60    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$1,200 |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

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:

| Cost Sharing                          |                |
|---------------------------------------|----------------|
| <a href="#">Deductibles</a>           | \$1,200        |
| <a href="#">Copayments</a>            | \$900          |
| Percentage <a href="#">Copayments</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.