**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. 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 or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,500 / individual or $3,000 / family | 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. Covered medical services listed without deductible and some prescription drug are covered before you meet your deductible. | 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?** | $8,700 Individual or $17,400/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 TX Find Care or call 1-888-858-3492 for a list of participating providers. | This plan uses a provider network. 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. |

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 (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/office visit | Not covered | None |
| | Specialist visit | $60 copay/office visit | Not covered | Preauthorization may be required, or services not covered. |
| | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 25% copayment after deductible /test for blood work<br>25% copayment after deductible per test for x- rays | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 25% copayment after deductible | Not covered | Preauthorization is required or Imaging services are not covered. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at MolinaMarketplace.com/ TXFormulary2024 | Generic drugs | $15 copay/prescription deductible does not apply (retail); $37.50 cost share for 90 day supply deductible does not apply (mail) | 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 two-and-a-half times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance |
| | Preferred brand drugs | $30 copay after deductible /prescription (retail); $75 cost share for 90 day supply after deductible (mail) | Not covered | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Non-preferred brand drugs | $60 copay after deductible /prescription (retail); $150 cost share for 90 day supply after deductible (mail) | Not covered | |
| | Specialty drugs | $250 copay after deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% copayment after deductible | Not covered | Preauthorization may be required, or services not covered. |
| | Physician/surgeon fees | 25% copayment after deductible | Not covered | Preauthorization may be required, or services not covered. Laser corrective eye surgery is not covered. |
| **If you need immediate medical attention** | Emergency room care | 25% copayment after deductible per visit | 25% copayment after deductible per visit | Emergency room care copay does not apply, if admitted to the hospital. |
| | Emergency medical transportation | 25% copayment after deductible | 25% copayment after deductible | None |
| | Urgent care | $45 copay/visit | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% copayment after deductible | Not covered | Preauthorization is required or services not covered. |
| | Physician/surgeon fees | 25% copayment after deductible | Not covered | None |
| **If you need mental health, behavioral health, or substance** | Outpatient services | $30 copay/office visit Outpatient Intensive Psychiatric Treatment Programs - 25% | Not covered | Preauthorization is required for Electroconvulsive Therapy (ECT), neuropsycological and psychological testing, |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **abuse services** | | copayment after deductible | | partial hospitalization, behavioral health treatment for PDD/autism, substance abuse services, Day Treatment, detoxification services and inpatient care or services not covered. |
| | Inpatient services | 25% copayment after deductible | 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 elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 25% copayment after deductible | Not covered | |
| | Childbirth/delivery facility services | 25% copayment after deductible | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not covered | 60 visits/year. Services must be provided by an in network Home health agency. |
| | Rehabilitation services | $30 copay/visit | Not covered | 35 visits/year. Medically necessary services only. Preauthorization is required for Occupational Therapy, Speech Therapy, Physical Therapy, Radiation therapy and radio surgery Rehabilitation services or services not covered. |
| | Habilitation services | $30 copay/visit | Not covered | 35 visits/year. Does not apply to MH/SUD conditions. |
| | Skilled nursing care | 25% copayment after deductible | Not covered | 25 days/calendar year. Preauthorization is required or services not covered. |
| | Durable medical equipment | 25% copayment after deductible | 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.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | | equipment. Preauthorization may be required or services not covered |
| | Hospice services | 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 check-up | Not Covered | Not covered | Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy. |

## Excluded Services & Other Covered Services:

**Services Your 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)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Infertility treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care (related to Rehabilitation benefits, combined 35 visit limit)
- Hearing aids (1 hearing aid every 36 months)
- Private Duty Nursing (Medically Necessary)
- Routine eye care (Adult)

**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 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.

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

**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 1-888-560-2025.

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, kwiijigo holne' 1-888-560-2025.

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

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

## 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** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment after deductible** **25%**
- **Other copayment after deductible** **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 | $1,500 |
| Copayments | $70 |
| Copayments % | $2,800 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,370** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment after deductible** **25%**
- **Other copayment after deductible** **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* | $900 |
| Copayments | $900 |
| Copayments % | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,800** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment after deductible** **25%**
- **Other copayment after deductible** **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* | $1,500 |
| Copayments | $300 |
| Copayments % | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,850** |

The plan would be responsible for the other costs of these EXAMPLE covered services.