




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 ? | \$500 / individual or \$1000 / 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 ? | \$9,200 Individual or \$18,400/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 | \$25 copay /office visit deductible does not apply | Not covered | None |
| | Specialist visit | \$75 copay /visit deductible does not apply | 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) | 45% copayment after deductible | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 35% copayment after deductible | Not covered | Preauthorization is required or Imaging services are not covered. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at MolinaMarketplace.com/TXFormulary2025 | Generic drugs | Retail: \$4 copay /prescription 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. Depending on Tier level this will be either a Copayment or a Coinsurance . Mail orders are subject to 3x retail cost-sharing amount and available on Tiers 1 -3. Mail order is not available for Specialty drugs , Tier 4. |
| | Preferred brand drugs | Retail: \$55 copay after deductible /prescription | Not covered | |
| | Non-preferred brand drugs | Retail: 50% copayment after deductible | Not covered | |
| | Specialty drugs | Retail: 50% copayment after deductible | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 45% copayment after deductible | Not covered | Preauthorization may be required, or services 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) | |
| | Physician/surgeon fees | 45% 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 | 45% copayment after deductible per visit | 45% copayment after deductible per visit | Emergency room care copay does not apply, if admitted to the hospital. |
| | Emergency medical transportation | 45% copayment after deductible | 45% copayment after deductible | None |
| | Urgent care | \$50 copay /visit deductible does not apply | Not covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 35% copayment after deductible | Not covered | Preauthorization is required or services not covered. |
| | Physician/surgeon fees | 35% copayment after deductible | Not covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 copay /office visit deductible does not apply; Outpatient Intensive Psychiatric Treatment Programs - 35% copayment after deductible | Not covered | Preauthorization is required for Electroconvulsive Therapy (ECT), neuropsychological and psychological testing, partial hospitalization , behavioral health treatment for PDD/autism, substance abuse services, Day Treatment, detoxification services and inpatient care or services not covered. |
| | Inpatient services | 35% 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 | 35% copayment after deductible | Not covered | |
| | Childbirth/delivery facility services | 35% copayment after deductible | Not covered | |
| If you need help recovering or have | Home health care | No Charge | Not covered | 60 visits/year. Services must be provided by an in network Home health agency. |

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| 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) | |
| other special health needs | Rehabilitation services | 45% copayment after deductible | 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 | 45% copayment after deductible | Not covered | 35 visits/year. Does not apply to MH/SUD conditions. |
| | Skilled nursing care | 45% copayment after deductible | Not covered | 25 days/calendar year. Preauthorization is required or services not covered. |
| | Durable medical equipment | 45% copayment after deductible | Not covered | Excludes vehicle modifications, home modifications, exercise, and bathroom 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 | Not covered | 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 .) | | |
|--|---|---|
| <ul style="list-style-type: none"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture Bariatric surgery Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Dental care (Child) Infertility treatment Long-term care | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine eye care (Adult) 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.) | | |
| <ul style="list-style-type: none"> Chiropractic care (related to Rehabilitation benefits, combined 35 visit limit) | <ul style="list-style-type: none"> Hearing aids (1 hearing aid every 36 months) | <ul style="list-style-type: none"> Private duty nursing (Medically Necessary) |

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

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.

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): Dine'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.

* 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 | \$500 |
| ■ Specialist copayment | \$75 |
| ■ Hospital (facility) copayment | 45% |
| ■ Other copayment | 45% |

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 | \$500 |
| Copayments | \$30 |
| Copayments % | \$5,400 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$5,930 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$75 |
| ■ Hospital (facility) copayment | 45% |
| ■ Other copayment | 45% |

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 * | \$500 |
| Copayments | \$1,100 |
| Copayments % | \$300 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,900 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$75 |
| ■ Hospital (facility) copayment | 45% |
| ■ Other copayment | 45% |

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 * | \$500 |
| Copayments | \$200 |
| Copayments % | \$700 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,400 |

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 1-888-560-2025 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



Non-Discrimination Notice – Section 1557
Molina Healthcare - Marketplace

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 1-888-560-2025 (TTY: 711). |
| Spanish Español | Para obtener servicios gratuitos de asistencia lingüística, así como ayudas y servicios auxiliares, llame al 1-888-560-2025 (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 1-888-560-2025 (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1-888-560-2025（TTY 用户请拨打 711）。 |
| Korean 한국인 | 무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-888-560-2025 (TTY: 711)로 연락 주시기 바랍니다. |
| Arabic العربية | اتصل على الرقم 1-888-560-2025 (الهاتف النصي 711) لتلقي خدمات المساعدة اللغوية المجانية والخدمات والمساعدات الإضافية. |
| Urdu اردو | زبان کی مفت معاونتی سروسز، معاونتی امداد اور سروسز کے لیے، 1-888-560-2025 (TTY: 711) پر کال کریں۔ |
| Tagalog | Para sa libreng serbisyo sa tulong sa wika, at mga auxiliary aid at serbisyo, tumawag sa 1-888-560-2025 (TTY: 711). |
| French Français | Pour bénéficier de services d'assistance linguistique gratuits, ainsi que de services et aides complémentaires, appelez le 1-888-560-2025 (ATS : 711). |
| Hindi हिंदी | निःशुल्क भाषा सहायता सेवाओं और सहायक ऐड एवं सेवाओं के लिए 1-888-560-2025 (TTY: 711) पर कॉल करें। |
| Persian فارسی | برای دریافت خدمات کمک زبانی رایگان، و کمک‌ها و خدمات اضافی با این شماره تماس بگیرید: 1-888-560-2025 (TTY: 711). |
| German Deutsch | Kostenlose Sprachassistenzen, Hilfsmittel und Dienstleistungen erhalten Sie unter 1-888-560-2025 (TTY: 711). |
| Gujarati | મફત ભાષા સહયોગ સેવાઓ અને સહાયક સાધનો તથા સેવાઓ માટે 1-888-560-2025 (TTY: 711) પર કોલ કરો. |

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| ગુજરાતી | |
| Russian Русский | Для получения бесплатных услуг языковой помощи, а также вспомогательных средств и услуг, позвоните: 1-888-560-2025 (телетайп: 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、1-888-560-2025（TTY: 711）までお電話ください。 |
| Laotian ພາສາລາວ | ສຳລັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນ ແລະ ການບໍລິການເສີມແບບບໍ່ເສຍຄ່າ, ໃຫ້ໂທ 1-888-560-2025 (TTY: 711). |