



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> ?                                | \$2500 / individual or \$5000 / 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 <a href="#">deductible</a> and some <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?              | No.                                                                                                                                                                              | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9250 / individual or \$18500 / 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="#">TX Find Care</a> or call 1-888-858-3492 for a list of participating <a href="#">providers</a> .                                                             | 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.

| 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        | \$30 <a href="#">copay</a> /office visit                                                      | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                        | \$90 <a href="#">copay</a> /visit                                                             | Not covered                                           | <a href="#">Preauthorization</a> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                        | <a href="#">Preventive care/screening</a> /immunization | 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.                                                                                                                                                                                                                                                                   |
| <b>If you have a test</b>                                                                                                                                                                              | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$50 <a href="#">copay</a> /test for blood work<br>25% per test for x-rays                    | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                            | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                | Not covered                                           | <a href="#">Preauthorization</a> is required or Imaging services are not covered.                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MolinaMarketplace.com/TXFormulary2026</a> | Generic drugs                                           | Retail: \$15 <a href="#">copay</a> /prescription<br><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. Depending on Tier level this will be either a <a href="#">Copayment</a> or a <a href="#">Coinsurance</a> . Mail orders are subject to 3x retail <a href="#">cost-sharing</a> amount and available on Tiers 1 -3. Mail order is not available for <a href="#">Specialty drugs</a> , Tier 4. |
|                                                                                                                                                                                                        | Preferred brand drugs                                   | Retail: \$100 <a href="#">copay</a> after <a href="#">deductible</a> /prescription            | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                        | Non-preferred brand drugs                               | Retail: 30% <a href="#">copayment</a> after <a href="#">deductible</a>                        | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                        | <a href="#">Specialty drugs</a>                         | Retail: 50% <a href="#">copayment</a> after <a href="#">deductible</a>                        | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center)          | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                | Not covered                                           | <a href="#">Preauthorization</a> 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<br>(You will pay the least)                                                                                                               | Non-Participating Provider<br>(You will pay the most)                      |                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                           | 25% <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>              | \$500 <a href="#">copayment</a> after <a href="#">deductible</a> per visit                                                                                       | \$500 <a href="#">copayment</a> after <a href="#">deductible</a> per visit | <a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital.                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Emergency medical transportation</a> | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | 25% <a href="#">copayment</a> after <a href="#">deductible</a>             | None                                                                                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Urgent care</a>                      | \$60 <a href="#">copay</a> /visit                                                                                                                                | Not covered                                                                | None                                                                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | Not covered                                                                | <a href="#">Preauthorization</a> is required or services not covered.                                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | 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 - 25% <a href="#">copayment</a> after <a href="#">deductible</a> | 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                               | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | Not covered                                                                |                                                                                                                                                                                                                                                                                                                                    |
| 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        | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | Not covered                                                                |                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services            | 25% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                   | 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                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Participating Provider<br>(You will pay the least)             | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 25%                                                            | Not covered                                           | 60 visits/year. Services must be provided by an in <a href="#">network</a> Home health agency.                                                                                                                                                                                   |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$30 <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>     | \$30 <a href="#">copay</a> /visit                              | Not covered                                           | 35 visits/year. Does not apply to MH/SUD conditions.                                                                                                                                                                                                                             |
|                                                                       | <a href="#">Skilled nursing care</a>      | 25% <a href="#">copayment</a> after <a href="#">deductible</a> | Not covered                                           | 25 days/calendar year. <a href="#">Preauthorization</a> is required or services not covered.                                                                                                                                                                                     |
|                                                                       | <a href="#">Durable medical equipment</a> | 25%                                                            | 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                                                                                                                                                                                                                                                                             |
| <b>If your child needs dental or eye care</b>                         | 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](#).)

- |                                                                                            |                         |                                                      |
|--------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------|
| • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture                                                                              | • Dental care (Child)   | • Routine eye care (Adult)                           |
| • Bariatric surgery                                                                        | • Infertility treatment | • Routine foot care                                  |
| • Cosmetic surgery                                                                         | • Long-term 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) |
|-----------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|

**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): 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.*

## 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> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 25%     |
| ■ Other <a href="#">copayment</a>                               | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$9        |
| <a href="#">Copayments</a>        | \$9        |
| <a href="#">Copayments %</a>      | \$9        |
| What isn't covered                |            |
| Limits or exclusions              | \$9        |
| <b>The total Peg would pay is</b> | <b>\$0</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> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 25%     |
| ■ Other <a href="#">copayment</a>                               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a> *     | \$9        |
| <a href="#">Copayments</a>        | \$9        |
| <a href="#">Copayments %</a>      | \$9        |
| What isn't covered                |            |
| Limits or exclusions              | \$9        |
| <b>The total Joe would pay is</b> | <b>\$0</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> | \$6,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 25%     |
| ■ Other <a href="#">copayment</a>                               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$9            |
| <a href="#">Copayments</a>        | \$9            |
| <a href="#">Copayments %</a>      | \$9            |
| What isn't covered                |                |
| Limits or exclusions              | \$9            |
| <b>The total Mia would pay is</b> | <b>\$0,200</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.