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 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?	$2,100 / individual or $4,200 / family Combined Medical and Rx	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. Preventive care, Family Planning, Pediatric Vision, Hospice, Formulary Preventive prescription drug	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?	$8,550 Individual or $17,100/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 www.MolinaMarketplace.com 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.

What You Will Pay				
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	Not covered	None
	Specialist visit	$50 copay/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)	$15 copay/test for blood work 20% copayment after	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% copayment after deductible per test	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/TXFormulary2022.com**	Generic drugs	$10 copay/prescription deductible does not apply (retail); $20 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 times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance
	Preferred brand drugs	$50 copay/prescription deductible does not apply (retail); $100 cost share for 90 day supply deductible does not apply (mail)	Not covered	
	Non-preferred brand drugs	30% copayment after deductible (retail); 2x cost share of 30% copayment after deductible for 90 day supply (mail)	Not covered	
	Specialty drugs	30% copayment after deductible	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 (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% copayment after deductible for facility per day	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% copayment after deductible per day	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	20% copayment after deductible per visit	20% copayment after deductible per visit	Emergency room care copayment does not apply, if admitted to the hospital.
	Emergency medical transportation	20% copayment after deductible per trip	20% copayment after deductible per trip	None
	Urgent care	$10 copay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% copayment after deductible per day	Not covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	20% copayment after deductible /visit	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit Outpatient Intensive Psychiatric Treatment Programs - 20% copayment after deductible per day	Not covered	Preauthorization is required for Electroconvulsive Therapy (ECT), neuropsycological 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	20% copayment after deductible per day	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	20% copayment after deductible per day /visit	Not covered	
	Childbirth/delivery facility services	20% copayment after deductible per day	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.

* 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 (You will pay the least)**	**Non-Participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
other special needs	Rehabilitation services	$50 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	$50 copay/visit	Not covered	35 visits/year. Does not apply to Mental / Behavioral Health Services and Substance Abuse Disorder Services conditions.
	Skilled nursing care	20% copayment after deductible per day	Not covered	25 days/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	20% copayment after deductible per request	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	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.

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)

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

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 $0
- Specialist copay $50
- Hospital (facility) copay per day after deductible 20%
- Other coinsurance 0%

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	$2,900
Copayments	$300
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

- The plan's overall deductible $0
- Specialist copay $50
- Hospital (facility) copay per day after deductible 20%
- Other coinsurance 0%

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	$800
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

- The plan's overall deductible $0
- Specialist copay $50
- Hospital (facility) copay per day after deductible 20%
- Other coinsurance 0%

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	$0
Copayments	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge, in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. If you need help, call (800) 368-1019; TTY (800) 537-7697.

LANGUAGE ACCESS

If you, or someone you're helping, have questions about Molina Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 (888) 560-2025.

Arabic	إذا كانت لديك أنت أو أي شخص آخر تساعده أسئلة حول Molina Marketplace، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث إلى مترجم فوري، اتصل على
Chinese	如果您，或是您正在協助的對象，有關於Molina Marketplace方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1 (888) 560-2025。
French	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Molina Marketplace, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1 (888) 560-2025.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Molina Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1 (888) 560- 2025 an.
Gujarati	જો તમને અથવા તમે જેને મદદ કરી રહ્યાં હોવ એવી કોઈ વ્યક્તિને Molina Marketplace વિશે પ્રશ્નો હોય, તો કોઈ ખર્ચે વગર તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1 (888) 560 2025 પર કૉલ કરો.
Hindi	यदि आपके या आपके द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Molina Marketplace के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ़्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी भी दूरभाषिए से बात करने के लिए, 1 (888) 560-2025 पर कॉल करें।
Japanese	ご本人様、またはお客様の身の回りの方でも、Molina Marketplace につい てご質問がございましたら、ご希望の言語でサポートを受けたり、情報 を入手したりすることができます。料金はかかりません。通訳とお話さ れる場合、1 (888) 560-2025までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Molina Marketplace 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1 (888) 560-2025로 전화하십시오.
Loatian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ຕ້ອງເສຍຄ່າບໍລິການ. ຖ້າທ່ານຕ້ອງການເວົ້າກັບລ່າມແປພາສາ, ກະລຸນາໂທຫາ 1 (888) 560-2025.
Persian-Farsi	اگر آپ، یا کوئی اور جن کی آپ مدد کر رہے ہیں، ان کے پاس Molina Marketplace کے بارے میں سوالات ہوں، تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق حاصل ہے۔ کسی ترجمان سے بات کرنے کے لیے، 1 (888) 560-2025 پر کال کریں۔
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Molina Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1(888) 560-2025.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Molina Markeplace tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (888) 560-2025.
Tagalog	Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Molina Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1 (888) 560-2025.
Urdu	اگر آپ، یا کوئی اور جن کی آپ مدد کر رہے ہیں، کے Molina Marketplace کے بارے میں کوئی سوال ہوں تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کیلئے 560-2025 (888) 1 پر کال کریں۔
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1 (888) 560-2025.