This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.molinahealthcare.com/tx/en-US/PDF/marketplace/summary-of-benefits-standard-silver-250-2016.pdf or by calling 1-888-560-2025.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$7,150** Individual, per year **$14,300** Family, per year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed 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.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.molinahealthcare.com/marketplace, or call 1-888-560-2025.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on pages 5. See your policy or plan document for additional information about **excluded services.**

Questions: Call 1-888-560-2025 or visit us at www.molinahealthcare.com/marketplace. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/cciio/ or call 1-888-560-2025 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments,** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay/visit	Not Covered	----------none----------
	Specialist visit	$75 Copay/visit	Not Covered	Prior authorization may be required, or services not covered.
	Other practitioner office visit	$30 Copay/visit	Not Covered	----------none----------
	Preventive care/screening/immunization	No Charge	Not Covered	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$85 Copay/x-ray $45 Copay/blood work	Not Covered	----------none----------
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1-888-560-2025**	Generic drugs	$35 Copay (per 30 day supply)(Retail)	Not Covered	Cost sharing for a 90-day supply by mail order is double the cost sharing for a standard 30-day supply. Available for Generic drugs, Preferred brand drugs, and Non-preferred brand drugs.
	Preferred brand drugs	$80 Copay (per 30 day supply)(Retail)	Not Covered	Cost sharing for a 90-day supply by mail order is double the cost sharing for a standard 30-day supply. Available for Generic drugs, Preferred brand drugs, and Non-preferred brand drugs.
	Non-preferred brand drugs	50% Coinsurance (per 30 day supply)(Retail)	Not Covered	Cost sharing for a 90-day supply by mail order is double the cost sharing for a standard 30-day supply. Available for Generic drugs, Preferred brand drugs, and Non-preferred brand drugs.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Specialty drugs	50% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
	Physician/surgeon fees	50% Coinsurance	Not Covered	
If you need immediate medical attention	Emergency room services	$650 Copay/visit	$650 Copay/visit	Does not apply, if admitted to the hospital.
	Emergency medical transportation	50% Coinsurance /visit	50% Coinsurance /visit	----------none----------
	Urgent care	$75 Copay/ visit	$75 Copay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
	Physician/surgeon fee	50% Coinsurance	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 Copay/visit (office visits) 50% Coinsurance (other outpatient services)	Not Covered	Prior authorization is required for services by Other Practitioners (Other than your PCP or Specialist Psychiatrist), or services not covered.
	Mental/Behavioral health inpatient services	50% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
	Substance use disorder outpatient services	$30 Copay/visit	Not Covered	Prior authorization is required for services by Other Practitioners (Other than your PCP or Specialist Psychiatrist) or services not covered.
	Substance use disorder inpatient services	50% Coinsurance	Not Covered	Prior authorization is required or services not covered.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	----------none----------
	Delivery and all inpatient services	50% Coinsurance	Not Covered	Notification only, Prior Authorization is not required. Pregnancy termination services, subject to restrictions and state law .

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to: Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by a home health aide. Limit is 60 visits per calendar year, Prior authorization is required after 7 visits for outpatient and home settings, or no services.
	Rehabilitation services	50% Coinsurance	Not Covered	Medically Necessary only
	Habilitation services	50% Coinsurance	Not Covered	Medically Necessary only
	Skilled nursing care	50% Coinsurance	Not Covered	25 days per calendar year, Prior authorization is required, or services not covered.
	Durable medical equipment	50% Coinsurance	Not Covered	Prior authorization is required for certain durable medical equipment, or services not covered.
	Hospice service	No Charge	Not Covered	Prior authorization not required, notification only.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	One office visit/exam per calendar year.
	Glasses	No Charge	Not Covered	Limited to: • One pair of standard frames and prescription lenses every 12 months • One pair of standard contact lenses every 12 months, in lieu of prescription glasses • Low vision optical devices, subject to coinsurance cost share, and limited to; Laser corrective surgery is not covered
	Dental check-up	Not Covered	Not Covered	Not Applicable

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless Medically Necessary
- Dental care (Adult)
- Dental Check-up (Child)
- Infertility treatment
- Laser corrective surgery
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (up to 35 visits per year)
- Hearing aids (one hearing aid every 36 months)
- Weight loss programs (Members 17years and older)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-560-2025. You may also contact your state insurance department at Texas Department of Insurance 1-800-252-3439.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, your state insurance department at Texas Department of Insurance 1-800-252-3439 or contact the insurer at 1-888-560-2025

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,640
- **Patient pays** $ 2,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$2,200
Limits or exclusions	$200
Total	**$2,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays** $ 2,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,800
Coinsurance	$600
Limits or exclusions	$100
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-888-560-2025 or visit us at www.molinahealthcare.com/marketplace. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/cciio/ or call 1-888-560-2025 to request a copy.

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	ﻥﺫﺇ ﻥﺎﻛ ﻚﻳﺪﻟ ﻭﺃ ﻯﺪﻟ ﺺﺨﺷ ﺪﻋﺎﺴﺗﻩ ﺔﻠﺌﺳﺃ ﺹﻮﺼﺨﺑ)Molina Marketplace(، ﻚﻳﺪﻠﻓ ﻖﺤﻟﺍ ﻲﻓ ﻝﻮﺼﺤﻟﺍ ﻰﻠﻋ ﺓﺪﻋﺎﺴﻤﻟﺍ ﺕﺎﻣﻮﻠﻌﻤﻟﺍﻭ ﺔﻳﺭﻭﺮﻀﻟﺍ ﻚﺘﻐﻠﺑ ﻦﻣ ﻥﻭﺩ ﺔﻳﺃ ﺔﻔﻠﻜﺗ. ﺙﺪﺤﺘﻠﻟ ﻊﻣ ﻢﺟﺮﺘﻣ ﻞﺼﺗﺍ ﺏ (1 (888) 560-2025).
Chinese	如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 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 [在此插入數字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 તમે અથવા તમે કોઇને મદદ કરી રહ્યા તેમ થી કોઇને [એસબીએમ ક ર્યક્રમન ન મ મકો] વિશ પ્રશ્નો હોર્ તો તમને મદદ અને મ હિતી મેળMolina Marketplaceનો અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ મ પ્ર પ્ત કરી શક ર્ છે. દભ ષિર્ોો1 (888) 560-2025 ત કરિ મ ટ,આ [અહીં દ ખલ કરો નબર] પર કોલ કરો.
Hindi	यदि आपक ,या आप द्वारा सहायता ककए जा रह ककसी व्यक्तत क Molina Marketplace क बार म प्रश्न ह ,तो आपक पास अपनी भाषा म मफ्त म सहायता और सचना प्राप्त करन का अधिकार ह। ककसी िभाषषए स बात करन क लिए ,1 (888) 560-2025 पर कॉि करा
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、1-888-560-4087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 위해서는1 (888) 560-2025로 전화하십시오.
Loatian	ຖ້າທ່ານ, ຫລືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1 (888) 560-2025.
Persian-Farsi	گار مشاءا ي سکیه ک مشا به وا کمک کیمی ي ، سو لا رد دروم Molina Marketplace ، شادتهدیشا ب ق ح ن یا ار رادید که کمک و اطاعلاته ب زبنا دوخ اره ب طور گ یاران فایردت امنییدد. 1 (888) 560-2025 سامت احصل یامنید.
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 Healthcare 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 tinutulangan, 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	رگا اپ یا سکو ک مدد ےد ہرے ہیں روا اپ نودودو کوسال ےہ Molina Marketplace ےکراب ے یمں،و ت اپ نودودو ک پانی نابز نیم فمت مدد روا امولاعمت احصل ےنو کاک قح ۔ےہ ئرنامج سےا بتر کنےےک لیے، 1 (888) 560-2025 نو فر کیں۔
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1 (888) 560-2025.

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