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, visit our website at MolinaMarketplace.com or call 1-888-296-7677. 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?	$6,500/Individual or $13,000/Family Deductible applies to Emergency room care, Prescription Drugs outpatient facilities and inpatient settings.	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, Home Healthcare services and Formulary Preventive Prescription Drugs 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?	For network providers $8,150 individual /$16,300 family; for out-of-network providers there is no coverage unless Prior Authorized by Molina Healthcare.	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 MolinaMarketplace.com or call 1-888-296-7677 for a list of network 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay, ded. does not apply /office visit	Not covered	Deductible waived for 1st visit to PCP, other practitioner or behavioral health provider.
	Specialist visit	$75 copay, ded. does not apply /office visit	Not Covered	Preauthorization may be required, or services not covered.
	Preventive care/screening/ immunization	No charge deductible does not apply	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) -	$40 copay, ded. does not apply/test for blood work 40% coinsurance after ded. / test for x- rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance 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 http://molinamarketplace.com/OHformulary2020	Tier 1	$25 copay ded. does not apply /prescription	Not Covered	Preauthorization may be required or services may not be covered. Up to 30-day supply – retail. Up to 90-day supply by mail order – offered at two times the 30-day retail Cost sharing. Coupons or any other form of third-party prescription drug cost sharing assistance will not apply toward any deductibles or annual out-of-pocket limits.
	Tier 2	$65 copay ded. does not apply /prescription (retail) 2x the 30day cost share (mail)	Not Covered	
	Tier 3	50% coinsurance after deductible (retail) 2x the 30day cost share (mail)	Not Covered	
	Tier 4	50% coinsurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered. -

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of- Network Provider (You will pay the most)	
	Physician/surgeon fees	40% coinsurance after deductible	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	40% copayment after deductible	Emergency room care coinsurance does not apply, if admitted to the hospital.
	Emergency medical transportation	40% coinsurance, deductible does not apply	40% copayment, deductible does not apply	None
	Urgent care	$30 copay ded. does not apply/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance after deductible	Not Covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	40% coinsurance after deductible	Not Covered	Preauthorization may be required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay ded. does not apply / office visit; Outpatient Intensive Psychiatric Treatment Programs - 40% coinsurance after deductible	Not Covered	Preauthorization is required or inpatient care or services not covered.
	Inpatient services	40% coinsurance after deductible	Not Covered	
If you are pregnant	Office visits	No Charge deductible does not apply	Not Covered	Cost sharing does not apply to routine prenatal and post-natal care 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). Pregnancy termination services are subject to restrictions and state law, and prior authorization may be required, or services may be not covered.
	Childbirth/delivery professional services	40% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	40% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge deductible does not apply	Not Covered	Limited to up to two (2) hours nursing per visit and up to four (4) hours home health aide per visit. Limit is 100 visits per calendar year for all home health visits except private duty nursing. Private duty nursing visits are limited to 90 visits per calendar year. Prior authorization may be required, or services may be not covered.
	Rehabilitation services	40% coinsurance after deductible/ office visit	Not Covered	Physical and Limited to:•20 visits/year per therapy - Physical, Speech, Occupational, Pulmonary Therapy•36 visits/year - Cardiac rehabilitation •12 visits/year – Manipulation Therapy Prior authorization may be required, or services may be not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	40% coinsurance t after deductible/ office visit	Not Covered	Preauthorization is required or services not covered.
	Skilled nursing care	40% coinsurance after deductible	Not Covered	Limited to 90 days per calendar year. Prior authorization is required, or services may be not covered.
	Durable medical equipment	40% coinsurance t ded. does not apply.	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Preauthorization may be required or services not covered.
	Hospice services	No Charge deductible does not apply	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge deductible does not apply	Not covered	Coverage limited to one exam/year.
	Children's glasses	No Charge deductible does not apply	Not covered	Coverage limited to one pair of standard frames and prescription lenses/year. Limited to one pair of Contact Lenses per 12 months, in lieu of Rx glasses as Medically Necessary for specified medical conditions. Low Vision Optical Devices and Services. Subject to limitations, and Prior Auth applies. Laser corrective surgery is not covered.
	Children's dental check-up	Not Covered	Not covered	None

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 Check-up (Child)
- Infertility treatment
- Laser eye corrective
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care

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

- Chiropractic Care (up to 35 visits per
- Hearing Aids (1 hearing aid every 36 months)
- Weight Loss Programs

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 at 1-888-560-2025 or the 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 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: the Texas Department of Insurance 1-800-252-3439.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$4,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,900

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

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,600

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

The plan's overall deductible	$6,500
Specialist copayment	$75
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$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.

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.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، المجانًا، لك. تتصل بقسم خدمات الأعضاء. يقع رقم الهاتف في الجزء الخلفي من بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտիետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، بدون هزینه در دسترس شما هستند. با خدمات اعضا تماس بگیرید. شماره تلفن روی پشت کارت شناسایی عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ.ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អកនសិទិទទួលនពត័ននេះក ងទ្រមង់ផ្សង ដូច ទ្រមង់សេមង អក្សរប ទំហំអក្សរធំយ៉ែតត្រមវ៉ពិេសសរបស់អក ឬរបស់អកេយមិនគិតតៃមបែនមេឡ៊ីយ។(Cambodian)