



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

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                     |                                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                          | Out-of- Network Provider<br>(You will pay the most)                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                           | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               | <a href="#">Preauthorization</a> may be required, or services not covered.                                                                                                                                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | 40% <a href="#">copayment</a> after <a href="#">deductible</a>            | <a href="#">Emergency room care coinsurance</a> does not apply, if admitted to the hospital.                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                           | <a href="#">Emergency medical transportation</a> | 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                                                                                                           | 40% <a href="#">copayment</a> , <a href="#">deductible</a> does not apply | None                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | <a href="#">Urgent care</a>                      | \$30 <a href="#">copay ded.</a> does not apply/visit                                                                                                                                  | Not Covered                                                               | None                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               | <a href="#">Preauthorization</a> is required or services not covered.                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               | <a href="#">Preauthorization</a> may be required or services not covered.                                                                                                                                                                                                                                                                                                                                                                                          |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copay ded.</a> does not apply / office visit; Outpatient Intensive Psychiatric Treatment Programs - 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> | Not Covered                                                               | <a href="#">Preauthorization</a> is required or inpatient care or services not covered.                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | Inpatient services                               | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                                    | No Charge <a href="#">deductible</a> does not apply                                                                                                                                   | Not Covered                                                               | <a href="#">Cost sharing</a> does not apply to routine prenatal and post-natal care 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). 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services            | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                                                                                                                      | Not Covered                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No Charge <a href="#">deductible</a> 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.                                                                                                                   |
|                                                                           | <a href="#">Rehabilitation services</a>          | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> / 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<br>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<br>(You will pay the least)                                      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                     |
|                                        | <a href="#">Habilitation services</a>     | 40% <a href="#">coinsurance</a> t after <a href="#">deductible</a> / office visit | Not Covered                                        | <a href="#">Preauthorization</a> is required or services not covered.                                                                                                                                                                                                                                                                               |
|                                        | <a href="#">Skilled nursing care</a>      | 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>                  | Not Covered                                        | Limited to 90 days per calendar year. Prior authorization is required, or services may be not covered.                                                                                                                                                                                                                                              |
|                                        | <a href="#">Durable medical equipment</a> | 40% <a href="#">coinsurance</a> t <a href="#">ded.</a> does not apply.            | 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 <a href="#">deductible</a> does not apply                               | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                |
| If your child needs dental or eye care | Children's eye exam                       | No Charge <a href="#">deductible</a> does not apply                               | Not covered                                        | Coverage limited to one exam/year.                                                                                                                                                                                                                                                                                                                  |
|                                        | Children's glasses                        | No Charge <a href="#">deductible</a> 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                                           |                                                                                                                                                                                                                                     |                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Check-up (Child)</li> <li>• Infertility treatment</li> <li>• Laser eye corrective</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S</li> </ul> | <ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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](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 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, 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> | \$6,500 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

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

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,900        |
| Copayments                        | \$300          |
| Coinsurance                       | \$4,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,900</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> | \$6,500 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$1,800        |
| Coinsurance                       | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$2,600</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> | \$6,500 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$75    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$200          |
| Coinsurance                       | \$700          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |



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
  - o Skilled sign language interpreters
  - o 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
  - o Skilled interpreters
  - o 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](mailto: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)

فأخذ دوجوم اذه فتاهلا مقر و. ءاضءلأ تامدخ مسقيل صتا. إكل، امجل، المساعدة اللغوية تامدخ حاتت، تبير عا مغللا مدختست تنك اذا: ميينة 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)

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Ձանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի 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)

هرامشد. ديریگب سامت اضعأ تامدخ اب. دنتسه امشد سرتسد رد هنیزه نودب، ی نابز كمك تامدخ، دینکی م تبحصی سراف نابز هبرگا؛ هجوت تسا مدش جرد امشد تبوضء ی یاسانش تراک تشپ یور نفلت. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਜ

(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)

អកនសិទិទទួលនពត៌នេន:ក ងទ្រមងផ្សង ដូច ទ្រមងសេមង អក្សរប ទំហំអក្សរធំយ៉ាងត្រមវវពិេសសរបស់អក

ប្ររបស់អកេយមិនគិតតែម៉ែនមេឡើយ។(Cambodian)