
 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 [www.MolinaMarketplace.com](http://www.MolinaMarketplace.com) or call 1-888-560-2025. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,925 / individual or \$5,850 / family Combined Medical and Rx	Generally, you must pay all of the costs from providers 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, Formulary Preventive <a href="#">prescription drug</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> ?	\$6,500 Individual or \$13,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.MolinaMarketplace.com">www.MolinaMarketplace.com</a> or call 1-888-560-2025 for a list of <a href="#">participating 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.

What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /office visit	Not covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$15 <a href="#">copay</a> /test for blood work 20% <a href="#">copayment</a> after	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">copayment</a> after <a href="#">deductible</a> per test	Not covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.molinamarketplace/TXFormulary2021.com">www.molinamarketplace/TXFormulary2021.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription <a href="#">deductible</a> does not apply (retail); \$20 cost share for 90 day supply <a href="#">deductible</a> does not apply (mail)	Not covered	<a href="#">Preauthorization</a> may be required or services may not be covered. Mail-order <a href="#">Prescription Drugs</a> are available at a 90-day supply and is offered at two times the 30-day retail prescription <a href="#">Cost Sharing</a> . Depending on Tier level this will be either a <a href="#">Copayment</a> or a <a href="#">Coinsurance</a>
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription <a href="#">deductible</a> does not apply (retail); \$100 cost share for 90 day supply <a href="#">deductible</a> does not apply (mail)	Not covered	
	Non-preferred brand drugs	30% <a href="#">copayment</a> after <a href="#">deductible</a> (retail); 2x cost share of 30% <a href="#">copayment</a> after <a href="#">deductible</a> for 90 day supply (mail)	Not covered	
	<a href="#">Specialty drugs</a>	30% <a href="#">copayment</a> after <a href="#">deductible</a>	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.Molinahealthcare.com](http://www.Molinahealthcare.com)

What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">copayment</a> after <a href="#">deductible</a> for facility per day	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	Physician/surgeon fees	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	<a href="#">Preauthorization</a> may be required, or services not covered. Laser corrective eye surgery is not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">copayment</a> after <a href="#">deductible</a> per visit	20% <a href="#">copayment</a> after <a href="#">deductible</a> per visit	<a href="#">Emergency room care copay</a> does not apply, if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">copayment</a> after <a href="#">deductible</a> per trip	20% <a href="#">copayment</a> after <a href="#">deductible</a> per trip	None
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> /visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	<a href="#">Preauthorization</a> is required or services not covered.
	Physician/surgeon fees	20% <a href="#">copayment</a> after <a href="#">deductible</a> /visit	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /office visit Outpatient Intensive Psychiatric Treatment Programs - 20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	<a href="#">Preauthorization</a> is required for Electroconvulsive Therapy (ECT), neuropsychological and psychological testing, partial <a href="#">hospitalization</a> , behavioral health treatment for PDD/autism, substance abuse services, Day Treatment, detoxification services and <a href="#">inpatient</a> care or services not covered.
	Inpatient services	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	
If you are pregnant	Office visits	No Charge	Not covered	<a href="#">Cost sharing</a> does not apply to routine prenatal care and first post-natal visit and certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day /visit	Not covered	
	Childbirth/delivery facility services	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	
If you need help recovering or have	<a href="#">Home health care</a>	No Charge	Not covered	60 visits/year. Services must be provided by an in <a href="#">network</a> Home health agency.

What You Will Pay				
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special needs	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> /visit	Not covered	35 visits/year. <a href="#">Medically necessary</a> services only. <a href="#">Preauthorization</a> is required for Occupational Therapy, Speech Therapy, Physical Therapy, Radiation therapy and radio surgery <a href="#">Rehabilitation services</a> or services not covered.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> /visit	Not covered	35 visits/year. Does not apply to Mental / Behavioral Health Services and Substance Abuse Disorder Services conditions.
	<a href="#">Skilled nursing care</a>	20% <a href="#">copayment</a> after <a href="#">deductible</a> per day	Not covered	25 days/calendar year. <a href="#">Preauthorization</a> is required or services not covered.
	<a href="#">Durable medical equipment</a>	20% <a href="#">copayment</a> after <a href="#">deductible</a> per request	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. <a href="#">Preauthorization</a> may be required or services not covered
	<a href="#">Hospice services</a>	No Charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	No Charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental checkups	Not Covered	Not covered	Not Applicable. Coverage can be purchased as a standalone product; it is not covered by this policy.

#### Excluded Services & Other Covered Services

Services Your <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> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Dental Care (Child)</li> <li>Infertility treatment</li> <li>Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S</li> <li>Routine eye care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</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.)		
<ul style="list-style-type: none"> <li>Chiropractic Care (related to Rehabilitation benefits, combined 35 visit limit)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (1 hearing aid every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing (<a href="#">Medically Necessary</a>)</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Molina Healthcare of Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: : Molina Healthcare of Texas at 1-888-560-2025 or Texas Department of Insurance 1-800-252-3439.

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? 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): Dinekehgo 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 [plan's](#) overall [deductible](#) \$0
- [Specialist copay](#) \$50
- Hospital (facility) [copay](#) per day 20% after [deductible](#)
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$2,900
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,700

What isn't covered	
Limits or exclusions	\$60

<b>The total Peg would pay is</b>	<b>\$4,960</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

**This EXAMPLE event includes services like:**

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$300

What isn't covered	
Limits or exclusions	\$20

<b>The total Joe would pay is</b>	<b>\$1,920</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$1,000

What isn't covered	
Limits or exclusions	\$0

<b>The total Mia would pay is</b>	<b>\$2,500</b>
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[The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.]



**Your Extended Family:**

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](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.



## LANGUAGE ACCESS

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

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