




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](http://MolinaMarketplace.com) or call 1-833-671-0051. 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.com](http://www.healthcare.gov/sbc-glossary.com) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$100/Individual or \$200/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> and services indicated in chart starting on Page 2.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	For <u>network providers</u> \$3,150 individual / \$6,300 family; for out-of-network <u>providers</u> there is no coverage unless <u>preauthorized</u> by Molina Healthcare.	The <u>out-of-pocket limit</u> out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://MolinaMarketplace.com/NVFindCare">MolinaMarketplace.com/NVFindCare</a> or call 1-833-671-0051 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$2 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse.
	<u>Specialist</u> visit	\$4 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> may be required, or services not covered.
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your plan will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after <u>deductible</u> /test for blood work  10% <u>coinsurance</u> after <u>deductible</u> for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required or Imaging services are not covered.
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://MolinaMarketplace.com/NVFormulary2024">MolinaMarketplace.com/NVFormulary2024</a>	Generic drugs	\$2 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply	Not Covered	<u>Preauthorization</u> 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-and-a-half times the 30 day retail <u>cost-sharing</u> . For brand drugs with a generic equivalent, coupons or any other form of third-party <u>prescription drug cost sharing assistance</u> will not apply toward any <u>deductibles</u> or annual <u>out-of-pocket limits</u> .
	Preferred brand drugs	\$20 <u>copay</u> /prescription (retail); <u>deductible</u> does not apply	Not Covered	
	Non-preferred brand drugs	10% <u>coinsurance</u> after <u>deductible</u> /prescription (retail)	Not Covered	
	<u>Specialty</u> drugs	10% <u>coinsurance</u> after <u>deductible</u> /prescription	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required, or services not covered.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required, or services not covered.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	<u>Cost-sharing</u> for <u>emergency room care</u> does not apply if admitted to the hospital.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	\$3 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required, or services not covered.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	<u>Preauthorization</u> is required, or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$2 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	No charge for the first 4 non-preventive office visits for any combination of primary care, mental health or substance abuse. <u>Preauthorization</u> is required for inpatient care or services not covered.
	Inpatient services	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	
If you are pregnant	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after <u>deductible</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered. One (1) medical social service consultation per course of treatment; One (1) nutrition consultation by a certified registered dietitian; and health aide services are furnished only when receiving nursing services or therapy.

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)	
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered. Combined limit of 120 days/visits per Member per calendar year (Including Speech, Occupational and Physical Therapy). Manipulation Therapy: 20 visits per year. Includes Cardiac Rehabilitation but does not include services provided on a non-monitored basis.
	<u>Habilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered. Combined limit of 120 days/visits per Member per calendar year (Including Speech, Occupational and Physical Therapy).
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered. Limited to 100 days per year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> after <u>deductible</u> /visit	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	No Charge	Not Covered	<u>Preauthorization</u> may be required, or services may not be covered.
<b>If your child needs dental or eye care</b>	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 (lenses and frames) or contact lenses in lieu of prescription glasses per year. Laser corrective surgery not covered.
	Children's dental check-up	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:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
• Abortion (except in cases of rape, incest, or	• Dental care (Adult)	• Routine eye care (Adult)

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

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|--|--|------------------------|
| when the life of the mother is endangered) | • Dental care (Child)                                | • Routine foot care    |
| • Acupuncture                              | • Long-term care                                     | • Weight loss programs |
| • Cosmetic surgery                         | • Non-emergency care when traveling outside the U.S. |                        |

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

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|-------------------------|------------------------|----------------|
| • Bariatric surgery     | • Chiropractic Care    | • Hearing Aids |
| • Infertility treatment | • Private duty nursing |                |

**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: Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234. 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: State of Nevada Office for Consumer Health Assistance, 3320 W. Sahara Ave, Suite 100, Las Vegas, NV 89102, (702) 486-3587, (888) 333-1597, Fax: (702) 486-3586, Email: [CHA@govcha.nv.gov](mailto:CHA@govcha.nv.gov).

**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? Not Applicable**

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.

*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 \$100
- Specialist copayment \$4
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,310</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$100
- Specialist copayment \$4
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$480</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$100
- Specialist copayment \$4
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$310</b>

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



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](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 <https://www.hhs.gov/ocr/complaints/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.



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ຂໍ້ຄວນລະອຽດ: Aids ແລະການບໍລິການສໍາລັບຄົນພິການ, ເຊັ່ນດຽວກັບຂອບເຂດໃນ braille ແລະການພິມຂະໜາດໃຫຍ່, ຍັງມີ.  
ທ່ານ ຕ້ອງ ການ ຄວາມ ຄ່ວຍ ເຫຼືອ ໃນ ພາ ສາ ຂອງ ທ່ານ call Member Services ທີ່ ຕັ້ງ ຢູ່ ທາງ ຫລັງ ຂອງ ບັດ ID ຂອງ ທ່ານ .  
(TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າ. (Loatian)

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attention: aids caux services bun mienh caux disabilities oix documents yie braille caux large print naaic yaac available da'faanh meih oix zuqc tengx yie meih nyei  
language heuc member services located zieqc back of meih nyei yie cie (tty: 711) these services naaic free of charge. (Mien)

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ਪਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਸੈਂਬਰ ਸੇਵਾਵਾਂ ਨੂੰ ਕਾਲ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ ਸੈਂਬਰ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਹੈ। (TTY: 711).  
ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬੁੱਲ ਅਤੇ ਵੱਡੇ ਫਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। (Punjabi)

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ВНИМАНИЕ: Если вам нужна помощь на вашем языке, позвоните в службу поддержки. Номер указан на обратной стороне вашей идентификационной карты. (Телетайп: 711).  
Также доступны вспомогательные средства и услуги для людей с ограниченными возможностями, такие как документы, напечатанные шрифтом Брайля и крупным шрифтом. Эти услуги бесплатны. (Russian)

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ATTENTION: Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print.  
Kung kailangan mo ng tulong sa iyong wika tumawag sa Member Services na matatagpuan sa likod ng iyong ID card. (TTY: 711).  
Ang mga serbisyong ito ay libre. (Tagalog)

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ความสนใจ: หากคุณต้องการความช่วยเหลือในภาษาของคุณโปรดติดต่อฝ่ายบริการสมาชิก หมายเลขจะอยู่ด้านหลังบัตรประจำตัวสมาชิกของคุณ (TTY: 711)  
นอกจากนี้ยังมีบริการช่วยเหลือสำหรับคนพิการ เช่น เอกสารอักษรเบรลล์และสิ่งพิมพ์ขนาดใหญ่ บริการเหล่านี้ไม่มีค่าใช้จ่าย (Thai)

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УВАГА: Якщо вам потрібна допомога вашою мовою, зателефонуйте до служби підтримки. Номер вказано на зворотному боці посвідчення учасника. (ЛТАЙП: 711).  
Також доступні допоміжні засоби та послуги для людей з обмеженими можливостями, такі як документи шрифтом Брайля та великим шрифтом. Ці послуги безкоштовні. (Ukrainian)

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CHÚ Ý: Nếu bạn cần trợ giúp bằng ngôn ngữ của mình, hãy gọi cho Dịch vụ Hội viên. Số này nằm ở mặt sau thẻ ID Hội viên của bạn. (TTY: 711).  
Hỗ trợ và dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in lớn, cũng có sẵn. Các dịch vụ này là miễn phí. (Vietnamese)

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