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 MolinaMarketplace.com or call 1-888-858-3492. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000/Individual or $4,000/Family Deductible applies to Emergency room care, Prescription Drugs outpatient facilities and inpatient settings.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, Family Planning, Pediatric Vision, Hospice, Home Healthcare services and Formulary Preventive Prescription Drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $7,800/individual / $15,600 family; for out-of-network providers there is no coverage unless Prior Authorized by Molina Healthcare.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See MolinaMarketplace.com or call 1-888-858-3492 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

**No charge for Covered Services at Indian Health Care Participating Provider (IHCP)s for qualified members

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/visit deductible does not apply	Not Covered	None
	Specialist visit	$60 Copay deductible does not apply	Not Covered	Preauthorization may be required, or services not covered.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$35 Copay/test for blood work deductible does not apply $60 Copay/test for x-rays deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Not Covered	Preauthorization is required or Imaging services are not covered
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://MolinaMarketplace.com/WIFormulary2021.com	Generic drugs	$20 Copay/prescription deductible does not apply	Not Covered	Preauthorization may be required, or services not covered. Mail-order Prescription Drugs are available at a 90-day supply and is offered at two times the 30-day retail prescription Cost Sharing. Depending on Tier level this will be either a Copayment or a Coinsurance. Coupons or any other form of third-party prescription drug cost sharing assistance will not apply toward any deductibles or annual out-of-pocket limits.
	Preferred brand drugs	$70 Copay/prescription deductible does not apply	Not Covered	
	Non-preferred brand drugs	$250 Copay/prescription	Not Covered	
	Specialty drugs	$250 Copay/prescription	Not Covered	Preauthorization is required, or services not covered. Mail order not available.
If you have outpatient	Facility fee (e.g., ambulatory	$600 Copay	Not Covered	Preauthorization may be required, or

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)	
surgery	surgery center)			services not covered.
	Physician/surgeon fees	$200 Copay	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	$800 Copay	$800 Copay	Emergency room care copay does not apply, if admitted to the hospital.
	Emergency medical transportation	$375 Copay deductible does not apply	$375 Copay deductible does not apply	None
	Urgent care	$60 Copay deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$800 Copay/day	Not Covered	Preauthorization is required or services not covered. 5 copay maximum.
	Physician/surgeon fees	No Charge	Not Covered	Preauthorization is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay/visit deductible does not apply	Not Covered	Preauthorization is required for inpatient care or services not covered. 5 copay maximum.
	Inpatient services	$800 Copay/day	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply to routine prenatal care and first post-natal visit and certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 5 copay maximum.
	Childbirth/delivery professional services	No charge	Not Covered	
	Childbirth/delivery facility services	$800 Copay/day	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	60 visits/year. Services must be provided by an in network Home health agency.
	Rehabilitation services	$35 Copay/visit deductible does not apply	Not Covered	20 visits/year - Speech, Physical, Occupational Therapy Copay amount reflects outpatient services only
	Habilitation services	$35 Copay/visit	Not Covered	20 visits/year - Speech, Physical,

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)	
		deductible does not apply		Occupational Therapy Copay amount reflects outpatient services only
	Skilled nursing care	$800 Copay/day	Not Covered	30 days/calendar year. Preauthorization is required or services not covered. 5 copay maximum.
	Durable medical equipment	30% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	Not Covered	Preauthorization is not required. Please notify Molina before services are rendered.
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 check-up	No charge	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Acupuncture
- Dental Care (Child)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Long-Term Care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Pregnancy termination
- Chiropractic Care
- Hearing Aids

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: Washington State Office of the Insurance Commissioner 1-800-562-6900. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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 Washington at 1-888-858-3492.

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.

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

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* For more information about limitations and exceptions, see the plan or policy document at MolinaMarketplace.com

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	**$2,000**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$800**
Other Coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

The plan's overall deductible	**$2,000**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$800**
Other Coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	**$2,000**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$800**
Other Coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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

MOLINA HEALTHCARE

Your Extended Family.

Molina Healthcare of Washington, Inc. (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

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:

- 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
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (888) 858-3492, TTY/TDD: 711.

If you believe that Molina has failed to provide these services or discriminated in another way, you can file a grievance with 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. Or, fax your complaint to (800) 816-3778.

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, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

MOLINA HEALTHCARE

Your Extended Family.

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.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-858-3492 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-858-3492 (TTY: 711).
Chinese	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 1-888-858-3492（TTY：711）。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-858-3492 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-858-3492 (TTY: 711) 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-858-3492 (телетайп: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-858-3492 (TTY: 711).
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-858 3492 (телетайп: 711).
Cambodian (Mon-Khmer)	សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ នោះមានសេវាកម្មជំនួយភាសាដោយឥតគិតថ្លៃសម្រាប់អ្នក។ សូមទូរសព្ទទៅលេខ 1-888-858-3492 (TTY៖ 711)។
Japanese	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。1-888-858-3492（TTY: 711）まで、お電話にてご連絡ください。
Amharic	ማስታወሻ፡ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለዉ ቁጥር ይደዉሉ 1-888-858-3492 (መስማት ለተሳናቸው: 711)።
Cushite	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-858-3492 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-858-3492 (رقم هاتف الصم والبكم: 711).
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1 (888) 858-3492 'ਤੇ ਕਾੱਲ ਕਰੋ।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-858-3492 (TTY: 711).
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຕ້ອງເສຍຄ່າບໍລິການ. ກະລຸນາໂທໂທຫາ 1-888-858-3492 (TTY: 711).