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, 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 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 deductible?	$750 / individual or $1,500 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in the chart starting on page 2.	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-carebenefits/.
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?	$2,500 / individual or $5,000 / family	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 www.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.

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	$10 copay/visit; deductible does not apply	Not covered	Eligible for two visits at $1 copay, after which stated cost sharing applies.
	Specialist visit	$30 copay/visit; 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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/test for x-rays; deductible does not apply $20 copay/test for blood work; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% 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 www.MolinaMarketplace.com/WAFormulary2024	Generic drugs - preferred	$12 copay/prescription; deductible does not apply	Not covered	Preauthorization may be required, or services not covered. Mail-order prescription drugs are available for up to a 90-day supply and is offered at two-and-a-half times (2.5x) the 30-day retail prescription drug cost sharing. Depending on formulary tier level this will be either a copay or coinsurance. For brand name drugs with a generic equivalent, coupons or any other form of third-party prescription drug cost sharing assistance will apply toward any deductibles or out-of-pocket limits.
	Preferred brand drugs	$35 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs and non-preferred generic drugs	$160 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs	$160 copay/prescription; deductible does not apply	Not covered	Preauthorization is required, or services not covered. Mail order not available.

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

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)	$325 copay	Not covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	$120 copay	Not covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	$425 copay	$425 copay	Emergency room care cost sharing does not apply if admitted to the hospital.
	Emergency medical transportation	$175 copay/visit; deductible does not apply	$175 copay/visit; deductible does not apply	None
	Urgent care	$30 copay/visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$425 copay/day	Not covered	Preauthorization is required or services not covered. Maximum of five (5) copays per inpatient stay.
	Physician/surgeon fees	Included in facility fee	Not covered	Preauthorization is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Free-standing Office Visit:** $10 copay/visit; deductible does not apply **Hospital Outpatient Department:** • Professional Fee: $10 copay/visit; deductible does not apply • Facility Fee: $325 copay/visit	Not covered	Mental health, behavioral health, or substance abuse free-standing office visit eligible for two visits at $1 copay, after which stated cost sharing applies.
	Inpatient services	$425 copay/day	Not covered	Preauthorization is required for inpatient care or services not covered. Maximum of five (5) copays per inpatient stay.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services,
	Childbirth/delivery	Included in facility fee	Not covered	

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

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)	
	professional services			coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Maximum of five (5) copays per inpatient stay.
	Childbirth/delivery facility services	$425 copay/day	Not covered	
If you need help recovering or have other special health needs	Home health care	$10 copay/day; deductible does not apply	Not covered	130 visits/year. Services must be provided by an in-network home health agency.
	Rehabilitation services	$20 copay/outpatient visit; deductible does not apply $425 copay/day for inpatient services	Not covered	Maximum of five (5) copays per inpatient stay. • 25 visits/year (Outpatient) and 30 days/year (Inpatient) - Speech, Physical, Occupational Therapy combined. • 10 visits/year - Spinal Manipulations • 12 visits/year - Acupuncture services
	Habilitation services	$20 copay/outpatient visit; deductible does not apply $425 copay/day for inpatient services	Not covered	Maximum of five (5) copays per inpatient stay. • 25 visits/year (Outpatient) and 30 days/year (Inpatient) - Speech, Physical, Occupational Therapy combined. • 10 visits/year - Spinal Manipulations • 12 visits/year - Acupuncture services
	Skilled nursing care	$425 copay/day	Not covered	60 visits/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	20% coinsurance	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	$10 copay/day; deductible does not apply	Not covered	Hospice respite benefit is limited to 14 days per lifetime. 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.

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

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)	
	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 plan.

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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Abortion
- Acupuncture
- Chiropractic care

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: Washington State Office of the Insurance Commissioner 1-800-562-6900.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-858-3492.

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	**$750**
Specialist copayment	**$30**
Hospital (facility) copayment	**$425**
Other coinsurance	**20%**

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	$750
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,750**

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

The plan's overall deductible	**$750**
Specialist copayment	**$30**
Hospital (facility) copayment	**$425**
Other coinsurance	**20%**

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	$750
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,650**

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

The plan's overall deductible	**$750**
Specialist copayment	**$30**
Hospital (facility) copayment	**$425**
Other coinsurance	**20%**

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	$600
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

Non-Discrimination Notification
Molina Healthcare of Washington, Inc.
Molina Marketplace

Molina Healthcare of Washington, Inc. ("Molina") complies with applicable Federal and Washington state civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to, and does not discriminate on the basis of, race, color, national origin, age, disability, sex, gender identity, or sexual identity. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - o Skilled sign language interpreters
    - o Written material in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
    - o Qualified interpreters
    - o Written material translated in your language
    - o Material that is simply written in plain language

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

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator at (866) 606-3889, or TTY, 711.

You can also email your complaint to civil.rights@molinahealthcare.com or fax your complaint to (800) 816-3778. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

If you send by mail, please mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also file a civil rights complaint with:

The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal. This is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Washington State Office of the Insurance Commissioner electronically through the Office of the Insurance Commissioner Complaint portal. This is available at https://www.insurance.wa.gov/file-complaint-or-check-yourcomplaint-status or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

Non-Discrimination Notification
Molina Healthcare of Washington, Inc.
Molina Marketplace

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	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា ោយមិនគិតឈ្ល គឺអាចមានសំរាំរំបើអ្នក។ ចូរ ទូរស័ព្ទ 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。 1-888-858-349（TTY: 711）まで、お電話にてご連絡ください。
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 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 متوافرة لك بالمجان. اتصل برقم 1-888-858-3492 (رقم الهاتف الخاص بالبكم: 711).

Punjabi ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਿਬ ਹੈ।
1-888-858-3492 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-858-3492 (TTY: 711).

Laotian ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-858-3492 (TTY: 711).