




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 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 ?	Individual: \$2,100 Family: \$4,200	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care , Primary Care, Specialist Visit, Mental Health and Substance Use Disorder Office Visits, Rehabilitative and Habilitative Services, Laboratory Services, Urgent Care, Preferred Generic Drugs, Preferred Brand 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 \$8,550 individual / \$17,100 family; for out-of-network providers there is no coverage unless Prior Authorized by Molina Healthcare.	The out-of-pocket limit out-of-pocket limit is the most you could pay in a year for covered services.
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 .

 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	None
	Specialist visit	\$50 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)	\$15 Copay for blood work, deductible does not apply 20% Coinsurance /test for x-rays	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 MolinaMarketplace.com	Generic drugs	\$10 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 times the 30-day retail prescription Cost Sharing . Depending on tier level this will be either a Copayment or a Coinsurance .
	Preferred brand drugs	\$50 Copay /prescription deductible does not apply	Not Covered	
	Non-preferred brand drugs	30% Coinsurance /prescription	Not Covered	For brand name drugs with a generic equivalent, 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 .
	Specialty drugs	30% Coinsurance /prescription	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)	20% Coinsurance	Not Covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	20% Coinsurance	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Emergency room care coinsurance does not apply, if admitted to the hospital.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	\$10 Copay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	Preauthorization is required or services not covered.
	Physician/surgeon fees	20% Coinsurance	Not Covered	Preauthorization is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$10 Copay /visit deductible does not apply Professional Fee: 20% Coinsurance Facility Fee: 20% Coinsurance	Not Covered	None
	Inpatient services	20% Coinsurance	Not Covered	Preauthorization is required for inpatient care or services 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
	Childbirth/delivery professional services	20% Coinsurance	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance	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)	
				(i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	130 visits/year. Services must be provided by an in-network Home health agency.
	Rehabilitation services	\$50 Copay /visit deductible does not apply	Not Covered	25 visits/year - Speech, Physical, Occupational Therapy combined 10 visits/year - Spinal Manipulations 12 visit/year - Acupuncture services Copay amount reflects outpatient services only
	Habilitation services	\$50 Copay /visit deductible does not apply	Not Covered	25 visits/year - Speech, Physical, Occupational Therapy combined 10 visits/year - Spinal Manipulations 12 visits/year - Acupuncture services Copay amount reflects outpatient services only
	Skilled nursing care	20% Coinsurance	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	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	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> Bariatric Surgery Cosmetic Surgery 	<ul style="list-style-type: none"> Dental Care (Child) Infertility Treatment 	<ul style="list-style-type: none"> Private Duty Nursing Routine Eye Care (Adult)

* For more information about limitations and exceptions, see the [plan](#) or policy document at MolinaMarketplace.com

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

- Dental Care (Adult)
- Non-Emergency Care Outside the U.S.
- Routine Foot Care

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

- Pregnancy Termination
- Acupuncture
- Spinal Manipulation

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.

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](#) \$2,100
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,100
Copayments	\$300
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,360

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,100
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,100
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.