MOLINA HEALTHCARE

## Molina Healthcare of Washington, Inc.: Molina Cascade Gold Plan

**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?** | $500/Individual<br>1,000/Family | 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, Family Planning, Pediatric Vision, Hospice, Formulary 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 $5,250 individual/ $10,500 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 | $15 Copay/visit deductible does not apply | Not Covered | None |
| | Specialist visit | $40 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) | $20 Copay/test for blood work deductible does not apply<br><br>$30 Copay/test for x-rays deductible does not apply | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $300 Copay | Not Covered | Preauthorization is required or Imaging services are not covered |
| **If you need drugs to treat your illness or condition**<br>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.<br>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. |
| | Preferred brand drugs | $60 Copay/prescription deductible does not apply | Not Covered | |
| | Non-preferred brand drugs | $100 Copay/prescription deductible does not apply | 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) | |
| | Specialty drugs | $100 Copay/prescription deductible does not apply | Not Covered | Preauthorization is required, or services not covered. Mail order not available. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $350 Copay | Not Covered | Preauthorization may be required, or services not covered. |
| | Physician/surgeon fees | $75 Copay | Not Covered | Preauthorization may be required, or services not covered. |
| **If you need immediate medical attention** | Emergency room care | $450 Copay | $450 Copay | Emergency room care coinsurance 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 | $35 Copay deductible does not apply | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $525 Copay/day deductible does not apply | 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 | Office Visit: $15 Copay deductible does not apply<br><br>Professional Fee: $15 Copay deductible does not apply<br><br>Facility Fee: $350 Copay | Not Covered | None. |

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| 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) | |
| | Inpatient services | $525 Copay/day copay does not apply | Not Covered | Preauthorization is required for inpatient care or services not covered. 5 copay maximum. |
| **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 | $525 Copay/day copay does not apply | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | Not Covered | 130 visits/year. Services must be provided by an in network Home health agency. |
| | Rehabilitation services | $25 Copay/visit deductible does not apply | Not Covered | 25 visits/year - Speech, Physical, Occupational Therapy combined<br>10 visits/year - Spinal Manipulations<br>12 visits/year - Acupuncture services<br>Copay amount reflects outpatient services only |
| | Habilitation services | $25 Copay/visit deductible does not apply | Not Covered | 25 visits/year - Speech, Physical, Occupational Therapy combined<br>10 visits/year - Spinal Manipulations<br>12 visits/year - Acupuncture services<br>Copay amount reflects outpatient services only |
| | Skilled nursing care | $350 Copay/day | Not Covered | 60 visits/calendar year. Preauthorization is required or services not covered. 5 copay maximum. |
| | 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. |

* 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 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.)**

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Child)
- Infertility Treatment
- Non-Emergency Care Outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- 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.*

* 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** | **$500** |
| **Specialist Copayment** | **$40** |
| **Hospital (facility) Copayment** | **$525** |
| **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 | $0 |
| Copayments | $900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$960** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist Copayment** | **$40** |
| **Hospital (facility) Copayment** | **$525** |
| **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 | $500 |
| Copayments | $1,200 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,780** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$500** |
| **Specialist Copayment** | **$40** |
| **Hospital (facility) Copayment** | **$525** |
| **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 | $500 |
| Copayments | $1,100 |
| Coinsurance | $50 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,650** |

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