Molina Healthcare of Washington, Inc.: Molina Constant Care Silver 1 Plan

Coverage for: Individual + Family | **Plan Type:** HMO

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?	$0	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. Preferred Generic Drugs, Preferred Brand Drugs are covered before you meet your prescription drug 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?	Yes, $800/individual or $1,600/family for prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $8,000 individual / $16,000 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	$30 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)	$45 Copay/test for blood work deductible does not apply $80 Copay/test for x-rays deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$700 Copay deductible does not apply	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	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 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. 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	40% Coinsurance prescription	Not Covered	
	Specialty drugs	40% Coinsurance	Not Covered	Preauthorization is required, or services not

* 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)	
		/prescription		covered. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copay deductible does not apply	Not Covered	Preauthorization may be required, or services not covered.
	Physician/surgeon fees	$75 Copay deductible does not apply	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	$750 Copay deductible does not apply	$750 Copay deductible does not apply	Emergency room care coinsurance does not apply, if admitted to the hospital.
	Emergency medical transportation	$500 Copay deductible does not apply	$500 Copay deductible does not apply	None
	Urgent care	$30 Copay deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,200 Copay per day	Not Covered	Preauthorization is required or services not covered. Two Copay maximum per admission.
	Physician/surgeon fees	$60 Copay	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $30 Copay/visit deductible does not apply Professional Fee: $75 Copay/visit deductible does not apply Facility Fee: $500 Copay/visit deductible does not	Not Covered	None

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)	
		apply		
	Inpatient services	$1,200 Copay per day deductible does not apply	Not Covered	Preauthorization is required for inpatient care or services not covered. Two Copay maximum per admission.
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). Two Copay maximum per admission.
	Childbirth/delivery professional services	$60 Copay deductible does not apply	Not Covered	
	Childbirth/delivery facility services	$1,200 Copay per day deductible does not apply	Not Covered	
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	$60 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
	Habilitation services	$60 Copay/visit deductible does not apply	Not Covered	30 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	$1,200 Copay per day deductible does not apply	Not Covered	60 visits/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	$500 Copay deductible does not apply	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.

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)	
	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.)

- 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	**$0**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$1,200**
Other Coinsurance	**0%**

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	$2,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,100**

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

The plan's overall deductible	**$0**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$1,200**
Other Coinsurance	**0%**

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

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

The plan's overall deductible	**$0**
Specialist Copayment	**$60**
Hospital (facility) Copayment	**$1,200**
Other Coinsurance	**0%**

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	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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