




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](http://www.healthcare.gov/sbc-glossary) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$600/Individual or \$1,200/Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , Inpatient services, primary care visits, specialist visits, mental health and substance use disorder office visits, mental health and substance use disorder outpatient services, rehabilitation services, habilitation services, laboratory services, x-rays and diagnostic imaging, urgent care, emergency medical transportation, other practitioner visits, hospice, home healthcare, and prescription drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,900 individual/ \$11,800 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See MolinaMarketplace.com or call 1-888-858-3492 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$15 <a href="#">Copay</a> /visit <a href="#">deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">Copay</a> <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">Copay</a> /test for blood work <a href="#">deductible</a> does not apply  \$30 <a href="#">Copay</a> /test for x-rays <a href="#">deductible</a> does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$300 <a href="#">Copay</a>	Not Covered	<a href="#">Preauthorization</a> is required or Imaging services are not covered
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MolinaMarketplace.com/WAFormulary2023</a>	Generic drugs	\$10 <a href="#">Copay</a> /prescription <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered. Mail-order <a href="#">Prescription Drugs</a> are available for up to a 90-day supply and is offered at 2.5 times the 30-day retail prescription <a href="#">Cost Sharing</a> . Depending on Tier level this will be either a <a href="#">Copayment</a> or a <a href="#">Coinsurance</a> . For brand name drugs with a generic equivalent, coupons or any other form of third-party <a href="#">prescription drug</a> cost sharing assistance will apply toward any <a href="#">deductibles</a> or annual <a href="#">out-of-pocket limits</a> .
	Preferred brand drugs	\$60 <a href="#">Copay</a> /prescription <a href="#">deductible</a> does not apply	Not Covered	
	Non-preferred brand drugs	\$100 <a href="#">Copay</a> /prescription <a href="#">deductible</a> 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)	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">Copay</a> /prescription <a href="#">deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is required, or services not covered. Mail order not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$350 <a href="#">Copay</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
	Physician/surgeon fees	\$75 <a href="#">Copay</a>	Not Covered	<a href="#">Preauthorization</a> may be required, or services not covered.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$450 <a href="#">Copay</a>	\$450 <a href="#">Copay</a>	<a href="#">Emergency room care coinsurance</a> does not apply, if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	\$375 <a href="#">Copay deductible</a> does not apply	\$375 <a href="#">Copay deductible</a> does not apply	None
	<a href="#">Urgent care</a>	\$35 <a href="#">Copay deductible</a> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$525 <a href="#">Copay/day deductible</a> does not apply	Not Covered	<a href="#">Preauthorization</a> is required or services not covered. 5 <a href="#">Copay</a> maximum.
	Physician/surgeon fees	No Charge	Not Covered	<a href="#">Preauthorization</a> is required or services not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Free-standing Office Visit:</b> \$15 <a href="#">Copay deductible</a> does not apply  <b>Hospital Outpatient Department:</b> <ul style="list-style-type: none"> <li>Professional Fee: \$15 <a href="#">Copay deductible</a> does not apply</li> </ul>	Not Covered	None.

\* 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)	
		<ul style="list-style-type: none"> <li>Facility Fee: \$350 <a href="#">Copay</a></li> </ul>		
	Inpatient services	\$525 <a href="#">Copay</a> /day	Not Covered	<a href="#">Preauthorization</a> is required for inpatient care or services not covered. 5 <a href="#">Copay</a> maximum.
<b>If you are pregnant</b>	Office visits	No charge	Not Covered	<a href="#">Cost sharing</a> does not apply to routine prenatal care and first post-natal visit and certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 5 <a href="#">Copay</a> maximum.
	Childbirth/delivery professional services	No charge	Not Covered	
	Childbirth/delivery facility services	\$525 <a href="#">Copay</a> /day	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$15 <a href="#">Copay</a>	Not Covered	130 visits/year. Services must be provided by an in-network home health agency.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">Copay</a> /visit <a href="#">deductible</a> does not apply	Not Covered	25 visits/year (Outpatient) and 30 visits/per year (Inpatient) - Speech, Physical, Occupational Therapy combined. 10 visits/year - Spinal Manipulations 12 visit/year - Acupuncture services <a href="#">Copay</a> amount reflects outpatient services only
	<a href="#">Habilitation services</a>	\$25 <a href="#">Copay</a> /visit <a href="#">deductible</a> does not apply	Not Covered	25 visits/year (Outpatient) and 30 visits/per year (Inpatient) - Speech, Physical, Occupational Therapy combined. 10 visits/year - Spinal Manipulations 12 visit/year - Acupuncture services <a href="#">Copay</a> amount reflects outpatient services only
	<a href="#">Skilled nursing care</a>	\$350 <a href="#">Copay</a> /day	Not Covered	60 visits/calendar year. <a href="#">Preauthorization</a> is required or services not covered. 5 copay maximum.
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom

\* 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)	
	<a href="#">Hospice services</a>	\$15 <a href="#">Copay</a>	Not Covered	equipment. Hospice respite benefit is limited to 14 days per lifetime. <a href="#">Preauthorization</a> is not required. Please notify Molina before services are rendered.
<b>If your child needs dental or eye care</b>	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)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-Emergency Care 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.)

- 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$525
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,000</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$525
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,000</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600
■ <a href="#">Specialist Copayment</a>	\$40
■ Hospital (facility) <a href="#">Copayment</a>	\$525
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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



**Non-Discrimination Statement  
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 health care services. Molina offers health care 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
  - Skilled sign language interpreters
  - 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:
  - Qualified 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/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](mailto: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

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**Your Extended Family.**

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-your-complaint-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>

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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፣ በገጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለዉ 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 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 ਮੁਫਤ ਉਪਲਬਧ ਹਨ। 1 (888) 858-3492 'ਤੇ ਕਾਲ ਕਰੋ।
- German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-858-3492 (TTY: 711).
- Laotian ຫາຍຂຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຕ້ອງຈ່າຍຄ່າບໍລິການ. ກະລຸນາໃຫ້ໃບໂທຫາ 1-888-858-3492 (TTY: 711).