

Molina Healthcare of Washington, Inc.: Constant Care Silver 1 100 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 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. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$1,025/individual or \$2,050/family	The 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	\$0 Copay /visit	Not Covered	None
	Specialist visit	\$10 Copay /visit	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)	\$10 Copay /test for blood \$30 Copay /test for x-rays	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$125 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 MolinaMarketplace.com/WAFormulary2023	Generic drugs	\$0 Copay /prescription	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 2.5 times the 30-day retail prescription Cost Sharing . Depending on Tier level this will be either a Copayment or a Coinsurance .
	Preferred brand drugs	\$10 Copay /prescription	Not Covered	
	Non-preferred brand drugs	10% 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 apply toward any deductibles or annual out-of-pocket limits .
	Specialty drugs	10% Coinsurance /prescription	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)	\$250 Copay	Not Covered	Preauthorization may be required, or services 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)	
	Physician/surgeon fees	\$50 Copay	Not Covered	Preauthorization may be required, or services not covered.
If you need immediate medical attention	Emergency room care	\$350 Copay	\$350 Copay	Emergency room care coinsurance does not apply, if admitted to the hospital.
	Emergency medical transportation	25% Coinsurance	25% Coinsurance	None
	Urgent care	\$0 Copay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 Copay /day	Not Covered	Preauthorization is required or services not covered. Two Copay maximum per admission.
	Physician/surgeon fees	\$10 Copay	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: \$0 Copay /visit Hospital Outpatient Department: Professional Fee: \$50 Copay /visit Facility Fee: \$250 Copay /visit	Not Covered	None
	Inpatient services	\$600 Copay /day	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
	Childbirth/delivery professional services	\$10 Copay	Not Covered	
	Childbirth/delivery facility services	\$600 Copay /day	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)	
				admission..
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	\$10 Copay /visit	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 Copay amount reflects outpatient services only
	Habilitation services	\$10 Copay /visit	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 Copay amount reflects outpatient services only
	Skilled nursing care	\$600 Copay /day	Not Covered	60 visits/calendar year. Preauthorization is required or services not covered.
	Durable medical equipment	25% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	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
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 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	\$0
■ Specialist Copayment	\$10
■ Hospital (facility) Copayment	\$600
■ Other Coinsurance	25%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$900

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	\$10
■ Hospital (facility) Copayment	\$600
■ Other Coinsurance	25%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist Copayment	\$10
■ Hospital (facility) Copayment	\$600
■ Other Coinsurance	25%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

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 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

MHW Part #2073-2108
MHW-8/31/2021



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>

MHW Part #2073-2108
MHW-8/31/2021

MHW01012022



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፣ በነጻ 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 ຫາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຕ້ອງຈ່າຍຄ່າບໍລິການ. ກະລຸນາໃຫ້ໃບໂທຫາ 1-888-858-3492 (TTY: 711).