Molina Healthcare of Washington, Inc.
Schedule of Benefits
Molina Cascade Gold

The Schedule of Benefits below is intended to be used to help Members determine coverage benefits and is a summary only. The Molina Healthcare of Washington, Inc. Agreement and Individual Evidence of Coverage should be consulted for a detailed description of benefits, limitations, and exclusions.

Notice: This Plan does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available through the Health Benefit Exchange. Please contact your insurance agent or the Health Benefit Exchange if you wish to purchase pediatric dental coverage or a standalone dental product.

If you are a qualifying American Indian or Alaska Native that has a Cost Sharing requirement in your Plan, then you will be responsible for Cost Sharing under this plan for any Covered Services not provided by a tribal health provider. Tribal health providers include the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization.

Except for Emergency Services and Post-Stabilization Services, Members must receive Covered Services from Participating Providers; otherwise, the services are not covered, and Members will be 100% responsible for payment and the payments will not apply to their Deductible or Annual Out-of-Pocket Maximum. The provider network is Molina Marketplace.

Deductible Type	At Participating Providers, Members Pay	
Medical Deductible		
Individual	$600	
Family (2 or more Members)	$1,200	
Prescription Drug Deductible		
Individual	$0	
Family (2 or more Members)	$0	
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, Members Pay**	
Individual	$5,900	
Family (2 or more Members)	$11,800	
[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Member's Annual Out of Pocket Maximum.		
Emergency Room and Urgent Care Services	**Members Pay**	
Emergency Room [2]	$450	Copayment after Deductible
Urgent Care (Participating Provider)	$35	Copayment per visit

[2] This cost does not apply if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital/Facility services, for applicable Cost Sharing)

Outpatient Services[3]	At Participating Providers, Members Pay	
Office Visit		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$15	Copayment per visit
Mental Health Services	$15	Copayment per visit
Substance Use Disorder Services	$15	Copayment per visit
Specialty Care	$40	Copayment per visit
Other Practitioner Care	$15	Copayment per visit
Outpatient Facility[3]	$350	Copayment after Deductible

[3] Please note, if a Member receives professional services in an on-campus or off-campus hospital-based clinic, additional Outpatient Facility Cost Share may apply to any separately billed facility fees. Professional fees for Evaluation and Management (E&M) services received in an on-campus or off-campus hospital-based clinic will be processed assessing the Member's Primary Care or Specialist Office Visit Cost Share.

Habilitative Services (Limited to 25 visits per calendar year. This limit does not apply to services for Autism)	$25	Copayment per visit
Rehabilitative Services -Speech, physical and occupational therapy, combined limit of 25 visits per calendar year -Spinal manipulations limited to 10 per calendar year -Acupuncture services limited to 12 per calendar year (limitation for acupuncture does not apply if done for chemical dependency)	$25	Copayment per visit
Mental Health Services (Non-Office Visit) (Includes outpatient mental health and behavioral health	$15	Copayment per visit

medically necessary treatments and eating disorder treatments for DSM classified disorders)		
Substance Use Disorder Services (Non-Office Visit) (Includes outpatient chemical dependency detoxification, and unlimited Acupuncture treatment services when provided for chemical dependency. All are subject to medical necessity criteria.)	$15	Copayment per visit
Nutritional Counseling	$15	Copayment per visit
Note: For laboratory and diagnostic X-ray services that are provided in a Primary Care Provider's (PCP) or Specialist's office, on the same date of service as a PCP or Specialist office visit, Members will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and X-ray Cost Sharing, as shown in this Schedule of Benefits, will apply if services are provided at a separate location, even if on the same day as an office visit.		
Phenylketonuria (PKU)		
Preventive Care	No Charge	
Testing and Treatment of PKU	$15	Copayment per visit
Diabetes Management		
Preventive Care	No Charge	
Diabetes Care other than Preventive Care	$15	Copayment per visit
Pediatric Vision Services (for Members under age 19 only)		
Comprehensive Vision Exam (Exam limited to one each calendar year.)	No Charge	
Prescription Glasses		
Frames • Limited to one pair of frames every calendar year • Limited to a selection of covered frames Lenses • Limited to one pair of lenses every calendar year	No Charge	

• Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, and ultraviolet protection (UV)		

Prescription Contact Lenses – One calendar year supply
 	
• In lieu of prescription glasses, prescription contact lenses covered with a minimum three-month supply for any of the following modalities every calendar year:
  • Standard (one pair annually)
  • Monthly (six-month supply, 2 times per calendar year)
  • Bi-weekly (three-month supply, 4 times per calendar year)
  • Dailies (three-month supply, 4 times per calendar year)
Medically necessary contact lenses for specified medical conditions require Prior Authorization.
	No Charge	

Low Vision Optical Devices and Services (subject to limitations and Prior Authorization applies)	No Charge	
Family Planning (These services include all contraceptive drugs, devices and products approved by the Federal Food and Drug Administration)	No Charge	
Outpatient Surgery		
Professional	$75	Copayment after Deductible
Facility	$350	Copayment after Deductible
Internally implanted devices (Surgically implanted hearing devices/cochlear implants, pacemakers, intraocular lenses, hip joints etc.)	20%	Coinsurance after Deductible

Advanced Imaging/Specialized Scanning Services (CT Scan, PET Scan, MRI) (Unless these services are performed while in an inpatient setting, Member's Cost Share amount for these services will apply.)	$300	Copayment after Deductible
Radiation Therapy (For the treatment of cancer, including neoplastic diseases of the head or neck)	20%	Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs	$100	Copayment
X-rays and Diagnostic Imaging	$30	Copayment
Laboratory Services	$20	Copayment
Mental Health and Substance Use Disorder		
Outpatient Mental Health and Substance Use Disorder Services, Outpatient Facility and Outpatient Intensive Psychiatric Treatment Programs	$15	Copayment
Dental and Orthodontic Services		
Dental Anesthesia (Medically Necessary)	$75	Copayment after Deductible
Orthodontic Services (Medically Necessary Services include: oral surgery due to trauma and reconstruction for cleft palate)	$75	Copayment after Deductible
Temporomandibular Joint Syndrome	$75	Copayment after Deductible
Inpatient Hospital / Facility Services	**At Participating Provider, Members Pay**	
All Inpatient Hospital Services • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder Services • Rehabilitative Services (Limit 30 days per calendar year) • Reconstructive Surgery	$525	Copayment per day (5 copay max)

Skilled Nursing Facility (limited to 60 days per calendar year) (Services must be billed by a Skilled Nursing Facility Participating Provider.)	$350	Copayment per day after Deductible
Long-Term Care Facility Following Hospitalization	$350	Copayment per day after Deductible
Hospice Care (limit 14 days)	$15	Copayment per day
Prescription Drug Coverage [4, 5]	**At Participating Provider, You Pay**	
Retail Pharmacy Prescription Drugs		
Tier 1 Drugs: Preferred Generic Drugs	$10	Copayment
Tier 2 Drugs: Preferred Brand-Name Drugs	$60	Copayment
Tier 3 Drugs: Non-Preferred Brand-Name and Non-Preferred Generic Drugs	$100	Copayment
Tier 4 Drugs: All Specialty Drugs; Brand-Name and Generic Specialty Drugs	$100	Copayment
Tier 5 Drugs: Preventive Drugs	No Charge	
Mail-order Prescription Drugs A 90-day supply is offered at two and a half times the 30- day retail prescription Cost Sharing. Depending on tier level this will be either a Copayment or a Coinsurance.		
Tier 1 Drugs: Preferred Generic Drugs	$25	Copayment
Tier 2 Drugs: Preferred Brand-Name Drugs	$150	Copayment
Tier 3 Drugs: Non-Preferred Brand-Name and Non-Preferred Generic Drugs	$250	Copayment
Tier 4 Drugs: All Specialty Drugs; Brand-Name and Generic Specialty Drugs	Not available for mail order	
Tier 5 Drugs: Preventive Drugs	No Charge	
[4] Please note, Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by the Member through the use of a discount card or coupon provided by a prescription drug		

manufacturer, or any other form of prescription drug third party Cost Sharing assistance, will not apply toward any Deductible, or the Annual Out-of-Pocket maximum under the Member's Plan.

[5] Cost-sharing for insulin is not subject to Deductible and is capped at $35 per thirty-day supply

Other Services	At Participating Providers, Members Pay	
Durable Medical Equipment (Includes, but not limited to authorized wheelchairs, scooters, and custom orthotics) This Cost Share applies to both purchase or rental of Durable Medical Equipment.	20%	Coinsurance after Deductible
Home Healthcare (limited to 130 visits per calendar year) (Services must be billed by a Home Healthcare agency that is a Participating Provider) (Separate Cost Sharing may apply for other covered benefits delivered in the home setting, e.g. injectable drugs, durable medical equipment, etc.)	$15	Copayment per day
Emergency Medical Transportation (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers)	$375	Copayment
Dialysis Services	20%	Coinsurance after Deductible
Infusion Therapy (Applies to outpatient and inpatient facility services only)	20%	Coinsurance after Deductible

MOLINA HEALTHCARE

Your Extended Family.

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

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

MOLINA HEALTHCARE

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 នោះមានសេវាកម្មជំនួយភាសាដោយឥតគិតថ្លៃ សម្រាប់អ្នក។ 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 ይደዉሉ 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 ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1 (888) 858-3492 'ਤੇ ਕਾੱਲ ਕਰੋ।
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-858-3492 (TTY: 711).
Laotian	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຕ້ອງເສຍຄ່າບໍລິການ. ກະລຸນາໂທໂທຫາ 1-888-858-3492 (TTY: 711).