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

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	$6,000
Family (2 or more Members)	$12,000
Prescription Drug Deductible	
Individual	Combined with Medical Deductible
Family (2 or more Members)	Combined with Medical Deductible
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, Members Pay**
Individual	$9,200
Family (2 or more Members)	$18,400

[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]	40%	Coinsurance after Deductible
Urgent Care (Participating Provider)	$100	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[4]	$50	Copayment per visit
Mental Health Services[5]	$50	Copayment per visit
Substance Use Disorder Services[5]	$50	Copayment per visit
Specialty Care	$100	Copayment per visit after Deductible
Other Practitioner Care	$50	Copayment per visit
Outpatient Facility[3]	40%	Coinsurance 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.

[4] Eligible for two visits at $1 copay, after which stated cost-sharing applies.

[5] Eligible for two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared between Mental Health and Substance Use Disorder Services.

Habilitative Services (Limited to 25 visits per calendar year. This limit does not apply to services for Autism.)	40%	Coinsurance after Deductible
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)	40%	Coinsurance after Deductible
Mental Health Services (Non-Office Visit) (Includes outpatient mental health and behavioral health medically necessary treatments and	40%	Coinsurance after Deductible

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.)	40%	Coinsurance after Deductible
Nutritional Counseling	$50	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	$50	Copayment per visit
Diabetes Management		
Preventive Care	No Charge	
Diabetes Care other than Preventive Care	$50	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 • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses	No Charge	

• 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	40%	Coinsurance after Deductible
Facility	40%	Coinsurance after Deductible
Internally implanted devices (surgically implanted hearing devices/cochlear implants, pacemakers, intraocular lenses, hip joints etc.)	40%	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.)	40%	Coinsurance after Deductible
Radiation Therapy (For the treatment of cancer, including neoplastic diseases of the head or neck)	40%	Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs	40%	Coinsurance after Deductible
X-rays and Diagnostic Imaging	40%	Coinsurance after Deductible
Laboratory Services	40%	Coinsurance after Deductible
Mental Health and Substance Use Disorder		
Outpatient Mental Health and Substance Use Disorder Services, Outpatient Facility and Outpatient Intensive Psychiatric Treatment Programs	40%	Coinsurance after Deductible
Dental and Orthodontic Services		
Dental Anesthesia (Medically Necessary)	40%	Coinsurance after Deductible
Orthodontic Services (Medically Necessary Services include: oral surgery due to trauma and reconstruction for cleft palate)	40%	Coinsurance after Deductible
Temporomandibular Joint Syndrome	40%	Coinsurance 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)	40%	Coinsurance after Deductible

• Reconstructive Surgery		
Skilled Nursing Facility (Limited to 60 days per calendar year) (Services must be billed by a Skilled Nursing Facility Participating Provider.)	40%	Coinsurance after Deductible
Long-Term Care Facility Following Hospitalization	40%	Coinsurance after Deductible
Hospice Care (limit 14 days)	$50	Copayment per day
Prescription Drug Coverage[6, 7]	**At Participating Provider, Members Pay**	
Retail Pharmacy Prescription Drugs		
Preferred Generic Drugs	$32	Copayment
Preferred Brand-Name Drugs	40%	Coinsurance after Deductible
Non-Preferred Brand-Name and Non-Preferred Generic Drugs	40%	Coinsurance after Deductible
All Specialty Drugs; Brand-Name and Generic Specialty Drugs	40%	Coinsurance after Deductible
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 formulary tier, this will be either a Copayment or a Coinsurance.		
Preferred Generic Drugs	$80	Copayment Not subject to Deductible
Preferred Brand-Name Drugs	33.33%	Coinsurance after Deductible
Non-Preferred Brand-Name and Non-Preferred Generic Drugs	33.33%	Coinsurance after Deductible
All Specialty Drugs; Brand-Name and Generic Specialty Drugs	Not available for mail order	
Preventive Drugs	No Charge	
[6] 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. [7] 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	40%	Coinsurance after Deductible

wheelchairs, scooters, and custom orthotics.) This Cost Share applies to both purchase or rental of Durable Medical Equipment.		
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.)	$50	Copayment per day
Emergency Medical Transportation (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	40%	Coinsurance after Deductible
Dialysis Services	40%	Coinsurance after Deductible
Infusion Therapy (Applies to outpatient and inpatient facility services only)	40%	Coinsurance after Deductible