

# 2020 Molina Marketplace Benefits At A Glance Mississippi



Benefits	Constant Care Silver 1 100	Constant Care Silver 1 150	Constant Care Silver 1 200	Constant Care Silver 1 250	Constant Care Silver 2 100	Constant Care Silver 2 150	Constant Care Silver 2 200	Constant Care Silver 2 250
Office Visit — Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Formulary Preventive Drugs*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Vision Exam and Eyewear	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.	No Charge Pediatric vision services available for members up to age 19.	No Charge Pediatric vision services available for members up to age 19.	No Charge Pediatric vision services available for members up to age 19.	No Charge Pediatric vision services available for members up to age 19.
Medical Deductible, Individual	\$0	\$750	\$3,500	\$6,000	\$0	\$0	\$3,450	\$6,500
Medical Deductible, Family — Entire Family of 2 or more	\$0	\$1,500	\$7,000	\$12,000	\$0	\$0	\$6,900	\$13,000
Rx Deductible, Individual	\$0	\$0	\$1,500	\$1,500	\$0	\$0	Included in Medical deductible	Included in Medical deductible
Rx Deductible, Family — Entire Family of 2 or more	\$0	\$0	\$3,000	\$3,000	\$0	\$0	Included in Medical deductible	Included in Medical deductible
Out of Pocket Maximum, Individual	\$1,500	\$2,700	\$6,500	\$8,150	\$1,200	\$2,700	\$6,500	\$8,150
Out of Pocket Maximum, Family — Entire Family of 2 or more	\$3,000	\$5,400	\$13,000	\$16,300	\$2,400	\$5,400	\$13,000	\$16,300
Emergency Room — Cost-sharing waived if admitted (Inpatient cost-sharing applies).	15%	25% (after ded)	40% (after ded)	40% (after ded)	25%	40%	40% (after ded)	40% (after ded)
Urgent Care	\$0	\$5	\$20	\$25	\$0	\$7	\$20	\$30
Office Visit — Primary Care	\$0	\$5	\$20	\$25	\$0	\$7	\$20	\$30
Office Visit — Specialty Care	\$15	\$30	\$60	\$75	\$10	\$20	\$40	\$75
Inpatient/ Medical / Surgical — Professional and Facility	15%	25% (after ded)	40% (after ded)	40% (after ded)	25%	40%	40% (after ded)	40% (after ded)
Pharmacy (Generic* / Brand* / Non-preferred* / Specialty)	\$0 / \$20 / 15% / 15%	\$5 / \$30 / 40% / 40%	\$12 / \$60 / 40% (after ded) / 40% (after ded)	\$15 / \$60 / 40% (after ded) / 40% (after ded)	\$0 / \$25 / 25% / 25%	\$7 / \$35 / 40% / 40%	\$20 / \$60 / 40% (after ded) / 40% (after ded)	\$25 / \$65 / 50% (after ded) / 50% (after ded)

ded = deductible \*Mail-order Rx drugs available for Tier-1: Preferred Generic Drugs, Tier-2: Preferred Brand Drugs, Tier-3: Non-Preferred Brand and Generic Drugs, Tier-5: Preventive Drugs. For mail-order Rx, a 90-day supply is provided at twice the 30-day retail cost-sharing amount.  
\*\*Applies to one visit for either PCP, Other Specialist or BH, not one visit for each provider type. This “Benefits At A Glance” is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion. Visit MolinaMarketplace.com for plan details.

Get the care you need at a price you can afford. Lean on Molina.  
Call today! (833) 946-1037

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Benefits	Core Care Bronze 1	Core Care Bronze 2	Confident Care Gold 1
Office Visit — Preventive Care	No Charge	No Charge	No Charge
Formulary Preventive Drugs*	No Charge	No Charge	No Charge
Vision Exam and Eyewear	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.	No Charge Pediatric vision services available for members up to age 19.	No Charge on Most Services Pediatric vision services available for members up to age 19. Adult vision services are available.
Medical Deductible, Individual	\$6,800 Combined Med/Rx	\$8,000 Combined Med/Rx	\$2,925 Combined Med/Rx
Medical Deductible, Family — Entire Family of 2 or more	\$13,600 Combined Med/Rx	\$16,000 Combined Med/Rx	\$5,850 Combined Med/Rx
Rx Deductible, Individual	Included in Medical deductible	Included in Medical deductible	Included in Medical deductible
Rx Deductible, Family — Entire Family of 2 or more	Included in Medical deductible	Included in Medical deductible	Included in Medical deductible
Out of Pocket Maximum, Individual	\$8,150	\$8,150	\$6,000
Out of Pocket Maximum, Family — Entire Family of 2 or more	\$16,300	\$16,300	\$12,000
Emergency Room — Cost-sharing waived if admitted (Inpatient cost-sharing applies).	40% (after ded)	50% (after ded)	20% (after ded)
Urgent Care	\$35	40% (after ded)	\$10
Office Visit — Primary Care	\$35	40% ded waived 1st visit, then 40% after deductible**	\$10
Office Visit — Specialty Care	\$85 (after ded)	40% (after ded)	\$50
Inpatient/ Medical / Surgical — Professional and Facility	40% (after ded)	40% (after ded)	20% (after ded)
Pharmacy (Generic* / Brand* / Non-preferred* / Specialty)	\$32 / 40% (after ded) / 50% (after ded) / 50% (after ded)	40% (after ded) / 40% (after ded) / 50% (after ded) / 50% (after ded)	\$10 / \$50 / 30% (after ded) / 30% (after ded)

ded = deductible \*Mail-order Rx drugs available for Tier-1: Preferred Generic Drugs, Tier-2: Preferred Brand Drugs, Tier-3: Non-Preferred Brand and Generic Drugs, Tier-5: Preventive Drugs. For mail-order Rx, a 90-day supply is provided at twice the 30-day retail cost-sharing amount.  
\*\*Applies to one visit for either PCP, Other Specialist or BH, not one visit for each provider type. This “Benefits At A Glance” is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion. Visit MolinaMarketplace.com for plan details.

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Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex. Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability. To help you talk with us, Molina provides services free of charge, in a timely manner: Aids and services to people with disabilities, Skilled sign language interpreters, Written material in other formats (large print, audio, accessible electronic formats, Braille), Language services to people who speak another language or have limited English skills, Skilled interpreters, Written material translated in your language. If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711). If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711. Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802. You can also email your complaint to [civil.rights@molinahealthcare.com](mailto:civil.rights@molinahealthcare.com). You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: <https://molinahealthcare.alertline.com>. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can mail it to: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201. You can also send it to a website through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. If you need help, call (800) 368-1019; TTY (800) 537-7697. 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.

<b>English</b>	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card.
<b>Spanish</b>	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro.
<b>Chinese</b>	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。
<b>Vietnamese</b>	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn.
<b>Tagalog</b>	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro.
<b>Korean</b>	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다.
<b>Arabic</b>	فجیرعت ٱقاطب فٱلحد دوجوم اذھ فٱتٱھلٱ مقروء. عاضدلاً تامدخ مسقٱل صٱٱا. اٱلء، اٱلأجمء، ٱٱوٱٱللا قءءاسملاً تامدخ حٱاٱءء، ٱٱٱٱر عٱلٱء مٱٱللاً مدٱٱٱسءءء اءلء: مٱٱٱنءء اٱلء: ٱصاخلاً وضرعلاً
<b>French Creole</b>	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a.
<b>Russian</b>	ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника.
<b>Armenian</b>	ՈՒՇԱՂԴՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Ձանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում:
<b>Japanese</b>	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。会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
<b>Farsi</b>	تشیب یور نفلء هرامشء دیریگب سامء اضءا تامدخ ابء. دنءسءه امشء سرءءسء ردء هنیز ه نوءبء، ی نایز كمء تامدخء، دینكیمء تبءصء ی سراق نایز ه برگا ءمءوءءءءسا مدشء چرء امشءء تبوءضعء یاسانشءء تراكء
<b>Punjabi</b>	ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਬਨਿਾਂ ਕਸਿੰ ਵਾਧੂ ਕੀਮਤ ਦੇ ਕਸਿੰ ਵੱਖਰੇ ਫਾਰਮੈਟ ਵਚਿ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਾਰ ਹੈ, ਜਵਿੰ ਕਵਿਖਾਸ ਜ਼ਰੂਰਤਾਂ ਕਾਰਨ ਆਡੀਓ, ਬ੍ਰੇਲ, ਜਾਂ ਵੱਡਾ ਫੋਂਟ ਜਾਂ ਫਚਿ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ।
<b>German</b>	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte.
<b>French</b>	ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre.
<b>Hmong</b>	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab.
<b>Cambodian</b>	អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេង ដូចជា ទម្រង់ជាសម្លេង អក្សរសរសេរ ទំហំអក្សរធំជាងសារតំពី ម្យ៉ាងការជាពិសេសរបស់អ្នក ឬជាភាសារបស់អ្នកជាយមិនគិតមូលបែនចម្លើយ។