MOLINA HEALTHCARE OF WASHINGTON, INC.
SCHEDULE OF BENEFITS
Core Care Bronze 1

THE SCHEDULE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF WASHINGTON, INC. AGREEMENT AND INDIVIDUAL POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

NOTICE: THIS PRODUCT 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. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. 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, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum. Your provider network is Molina Marketplace.

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$0
Family (2 or more Members)	$0
Prescription Drug Deductible (Applies to Tier 3 and Tier 4)	
Individual	$3,000
Family (2 or more Members)	$6,000
Annual Out of Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$8,550
Family (2 or more Members)	$17,100

[1]Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your Annual Out of Pocket Maximum.

Emergency Room and Urgent Care Services		You Pay
Emergency Room[2]	$1,850	Copayment
Urgent Care (Participating Provider)	$60	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 to You)

Outpatient Surgical and Non-Surgical Services[3]	At Participating Providers, You Pay	
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$60	Copayment per visit
Specialty Care	$150	Copayment per visit
Other Practitioner Care	$60	Copayment per visit
Habilitative Services (limited to 25 visits per calendar year. This does not apply to services for Autism)	$80	Copayment
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)	$80	Copayment
Mental Health Services (Includes mental health and behavioral health medically necessary treatments and eating disorder treatments for DSM classified disorders)	$60	Copayment per visit
Substance Use Disorder Services (Includes chemical dependency detoxification, and; unlimited Acupuncture treatment services when provided for chemical dependency. All are subject to medical necessity criteria.)	$60	Copayment per visit
Nutritional Counseling	$60	Copayment per visit

Note: For laboratory and diagnostic x-ray services that are provided in a PCP's or Specialist's office, on the same date of service as a PCP or Specialist office visit, You will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and x-ray Cost-Sharing, as shown in the 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 for Children and Adults	No Charge	
Testing and Treatment of PKU	$60	Copayment per visit
Diabetes Management		
Preventive Care for Children and Adults	No Charge	
Diabetes Care other than Preventive Care	$60	Copayment per visit
Cancer Chemotherapy and Other Provider Administered Drugs. **Note:** Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	$130	Copayment
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 • All lenses include scratch resistant coating, and ultraviolet protection (UV)	No Charge	
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	

[3] Please note, if You are seen in a hospital-based clinic, outpatient hospital Cost Sharing will apply to

facility and ancillary charges. Associated professional fees, limited to Evaluation and Management (E&M) services will be processed assessing Your PCP or Specialist Cost Sharing.

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgery		
Professional	$100	Copayment
Facility	$130	Copayment
Internally implanted devices (surgically implanted hearing devices/cochlear implants, pacemakers, intraocular lenses, hip joints etc.)	$130	Copayment

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Specialized Scanning Services (CT Scan, PET Scan, MRI) (Unless these services are performed while You are in an inpatient setting, Your Cost Share amount for these services will apply.)	$1,000	Copayment
Radiation Therapy (for the treatment of cancer)	$130	Copayment
Cancer Chemotherapy and Other Provider Administered Drugs. Note: Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	$130	Copayment
Radiology Services (X-rays)	$140	Copayment
Dental Services (Radiation therapy of cancer or neoplastic diseases of the head or neck)	$140	Copayment
Laboratory Services	$60	Copayment

Mental Health		
Outpatient Intensive Psychiatric Treatment Programs	$130 – Facility $100 - Professional	Copayment
Dental & Orthodontic Services		
Dental Anesthesia (Medically Necessary)	$100	Copayment
Orthodontic Services (Medically Necessary Services include: oral surgery due to trauma and reconstruction for cleft palate)	$100	Copayment
Temporomandibular Joint Syndrome (Medically necessary surgical and arthroscopic treatment)	$100	Copayment
Inpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Medical / Surgical		
Professional Physician/Surgeon Fee • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Abuse Disorder • Rehabilitative Services (Limit 30 days per calendar year) • Reconstructive Surgery	$150	Copayment
Facility Fee (e.g., hospital room) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder • Rehabilitative Services (Limit 30 days per calendar year) • Reconstructive Surgery	$1,500/Day	Copayment (2 copay max)
Skilled Nursing Facility (limited to 60 days per calendar year) (Services must be billed by a Skilled Nursing Facility Participating Provider.)	$1,500/Day	Copayment
Long-Term Care Facility Following Hospitalization	$1,500/Day	Copayment
Hospice Care	No Charge	

Please refer to Prescription Drug Section for a description of Prescription Drug benefits.

Prescription Drug Coverage [4, 5]	At Participating Providers, You Pay	
Retail Pharmacy Prescription Drugs		
Tier 1 Drugs: Preferred Generic Drugs	$27	Copayment
Tier 2 Drugs: Preferred Brand-Name Drugs	$130	Copayment
Tier 3 Drugs: Non-Preferred Brand-Name and Non-Preferred Generic Drugs	50%	Coinsurance after Rx Deductible
Tier 4 Drugs: All Specialty Drugs; Brand-Name and Generic Specialty Drugs	50%	Coinsurance after Rx Deductible
Tier 5 Drugs: Preventive Drugs	No Charge	
Mail-order Prescription Drugs	A 90-day supply is offered at two 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	$54	Copayment
Tier 2 Drugs: Preferred Brand-Name Drugs	$260	Copayment
Tier 3 Drugs: Non-Preferred Brand-Name and Non-Preferred Generic Drugs	33.33%	Coinsurance after Rx Deductible
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 You 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 Your Plan.

[5] Cost-sharing for insulin is not subject to deductible and is capped at $100 per thirty day supply

Other Services	At Participating Providers, You Pay	
Durable Medical Equipment (Includes but not limited to: wheelchairs, scooters, and custom orthotics)	$130	Copayment
Home Healthcare (limited to 130 visits) (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.)	No Charge	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers. However, You may be responsible for provider charges that exceed the allowed amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.)	$130	Copayment
Dialysis Services	$150	Copayment
Infusion Therapy (Applies to outpatient and inpatient facility services only)	$130	Copayment

MOLINA HEALTHCARE

Your Extended Family.

Molina Healthcare of Washington, Inc. (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

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:

- 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
    - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (888) 858-3492, TTY/TDD: 711.

If you believe that Molina has failed to provide these services or discriminated in another way, you can file a grievance with 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. Or, fax your complaint to (800) 816-3778.

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, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

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).