MOLINA HEALTHCARE OF WASHINGTON, INC.
SCHEDULE OF BENEFITS
Molina Cascade Gold

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	$500
Family (2 or more Members)	$1,000
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, You Pay**
Individual	$5,250
Family (2 or more Members)	$10,500

[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]	$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 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	$15	Copayment per visit
Specialty Care	$40	Copayment per visit
Other Practitioner Care	$15	Copayment per visit
Habilitative Services (limited to 25 visits per calendar year. This 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 (Includes mental health and behavioral health medically necessary treatments and eating disorder treatments for DSM classified disorders)	$15	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.)	$15	Copayment per visit
Nutritional Counseling	$15	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	$15	Copayment per visit
Diabetes Management		
Preventive Care for Children and Adults	No Charge	
Diabetes Care other than Preventive Care	$15	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.	20%	Coinsurance after deductible
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	$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
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.)	$300	Copayment after deductible
Radiation Therapy (for the treatment of cancer)	20%	Coinsurance after deductible
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.	20%	Coinsurance after deductible
Radiology Services (X-rays)	$30	Copayment
Dental Services (Radiation therapy of cancer or neoplastic diseases of the head or neck)	$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 & 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 (Medically necessary surgical and arthroscopic treatment)	$75	Copayment after deductible
Inpatient Hospital / Facility Services		**At Participating Providers, You 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	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	$10	Copayment

Prescription Drug Coverage [4, 5]	At Participating Providers, You Pay	
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 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	$20	Copayment
Tier 2 Drugs: Preferred Brand-Name Drugs	$120	Copayment
Tier 3 Drugs: Non-Preferred Brand-Name and Non-Preferred Generic Drugs	$200	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 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)	20%	Coinsurance after Deductible

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.)	20%	Coinsurance after Deductible
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.)	$375	Copayment

Other Services	**At Participating Providers, You Pay**	
Dialysis Services	20%	Coinsurance after Deductible
Infusion Therapy (Applies to outpatient and inpatient facility services only)	20%	Coinsurance after Deductible