

Molina Choice Bronze

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MolinaMarketplace.com or by calling 1-888-858-3492

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual \$6,650 Family of 2 or more \$13,300 Deductible waived for preventive care, Generic Drugs, Preventive Drugs, Primary Care OV, Other Practitioner OV, MH/SA OV, Family Planning, Pediatric Vision, and Hospice.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. Prescription Drug Deductible Combined with Medical	You must pay all of the costs for these services up to the deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$7,150 Individual, per year \$14,300 Family, per year	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket</u>	Premium, balance-billed charges, and non-covered care	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of participating providers, see www.MolinaMarketplace.com , or call 1-888-858-3492	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$ 35 Copay/visit	Not Covered	-----none-----
	Specialist visit	\$80 Copay/visit After Deductible	Not Covered	Prior authorization may be required, or services not covered
	Other practitioner office visit	\$35 Copay/visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	\$80 Copay/x-ray \$35 Copay/blood work After Deductible	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	40% Coinsurance After Deductible	Not Covered	Prior authorization may be required, or services not covered
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.molinahealthcare.com/members/wa/en-US/PDF/Marketplace/formulary-2017.pdf	Generic drugs	\$33 Copay	Not Covered	Mail-order Prescription Drugs are available at a 90-day supply and 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.
	Preferred brand drugs	\$65 Copay After Deductible	Not Covered	
	Non-preferred brand drugs	50% Coinsurance After Deductible	Not Covered	
	Specialty drugs	50% Coinsurance After Deductible	Not Covered	Prior authorization is required, or services not covered.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance After Deductible	Not Covered	Prior authorization may be required, or services not covered.
	Physician/surgeon fees	40% Coinsurance After Deductible	Not Covered	
If you need immediate medical attention	Emergency room services	\$350 Copay/visit After Deductible	\$350 Copay/visit After Deductible	Does not apply, if admitted to the hospital.
	Emergency medical transportation	\$100 Copay/visit After Deductible	\$100 Copay/visit After Deductible	-----none-----
	Urgent care	\$75 Copay/visit After Deductible	\$75 Copay/visit After Deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance After Deductible	Not Covered	Prior authorization is required, or services not covered.
	Physician/surgeon fee	40% Coinsurance After Deductible	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 Copay/visit	Not Covered	Prior authorization may be required, or services not covered.
	Mental/Behavioral health inpatient services	40% Coinsurance After Deductible	Not Covered	Prior authorization is required, or services not covered.
	Substance use disorder outpatient services	\$35 Copay/visit	Not Covered	Prior authorization may be required, or services not covered.
	Substance use disorder inpatient services	40% Coinsurance After Deductible	Not Covered	Prior authorization is required, or services not covered.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Includes prenatal and first postpartum exam
	Delivery and all inpatient services	40% Coinsurance After Deductible	Not Covered	Notification only, Prior Authorization is not required. Pregnancy termination services, subject to restrictions and state law.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge After Deductible	Not Covered	Limited to: <ul style="list-style-type: none"> Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by a home health aide. Limit is 130 visits per calendar year, Prior authorization is required, or no services.
	Rehabilitation services	40% Coinsurance After Deductible	Not Covered	25 visits/year - Speech, Physical, Occupational Therapy combined 10 visits/year - Spinal Manipulations 12 visit/year - Acupuncture services Prior authorization is required, or services not covered
	Habilitation services	40% Coinsurance After Deductible	Not Covered	There is a limitation of 25 visits/year for outpatient and a 30 day/year for inpatient. Prior authorization is required, or services not covered.
If you need help recovering or have other special health needs	Skilled nursing care	40% Coinsurance After Deductible	Not Covered	Limited to 60 days per calendar year. Prior authorization is required, or services not covered.
	Durable medical equipment	40% Coinsurance After Deductible	Not Covered	Prior authorization is required, or services not covered.
	Hospice service	No Charge	Not Covered	Notification only for inpatient care. Prior authorization is not required. Please notify Molina before services are rendered.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	One screening/exam per calendar year.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Glasses	No Charge	Not Covered	Limited to: <ul style="list-style-type: none"> • One pair of frames and prescription lenses every 12 months • One pair of contact lenses every 12 months, in lieu of prescription glasses • Low vision optical devices, every 5 years, subject to coinsurance cost share -Prior Auth. Laser corrective surgery is not covered
	Dental check-up	Not Covered	Not Covered	Not Applicable

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic surgery
- Hearing aids
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Dental care (Child)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Weight Loss programs
- Long-term care
- Pregnancy termination

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-858-3492. You may also contact your state insurance department at the Washington State Office of the Insurance Commissioner 1-800-562-6900.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-888-858-3492.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services: Spanish (Español): Para obtener asistencia en Español, llame al 1-888-858-3492

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$480
- Patient pays \$ 7,060

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$6,650
Copays	\$20
Coinsurance	\$240
Limits or exclusions	\$150
Total	\$7,060

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$1,580
- Patient pays \$3,820

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,420
Copays	\$1320
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$3,820

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Language Access

If you, or someone you're helping, have questions about Molina Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-858-3492.

Amharic	እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Molina Marketplace ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1- 888-858-3492 ይደውሉ።
Arabic	إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Molina Marketplace, فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-858-3492.
Chinese	如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Molina Marketplace 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字1-888-858-3492。
Cushite-Oromo	Isin yookan namni biraa isin deeggartan Molina Marketplace irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-888-858-3492 tiin bilbilaa.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zum Molina Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-858-3492 an.
Japanese	ご本人様、またはお客様の身の回りの方でも、Molina Marketplace についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、1-888-858-3492 までお電話ください。
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Molina Marketplace 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-858-3492 로 전화하십시오.
Laotian	ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-888-858-3492.
Cambodian-Mon-Khmer	ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងតែជួយ មានសំណួរអំពី Molina Marketplace ទេ, អ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មាន ទៅក្នុងភាសា របស់អ្នក ដោយមិនអស់ប្រាក់ ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-888-858-3492 ។
Punjabi	ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਸੀਂ ਜਿਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Molina Marketplace ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ. ਦੁਆਰਾ 1-888-858-3492 ਤੇ ਕਾਲ ਕਰੋ.

Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Molina Marketplace, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-858-3492.
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Molina Healthcare tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-858-3492.
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Molina Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-858-3492.
Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання Molina Marketplace, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-888-858-3492.
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-858-3492.



Your Extended Family.

Non-Discrimination Notification
Molina Healthcare of Washington, Inc.
Molina Marketplace

Molina Healthcare of Washington (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 (800) 869-7165, TTY/TTD: 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.