

Molina Marketplace Benefits At A Glance - Washington

Affordable, quality health coverage for all. Learn more at [ChooseMolina.com](https://www.ChooseMolina.com).

Call today! (833) 543-1893 (TTY: 711)



Included in your plan at NO additional cost!



Teladoc Virtual Care
Visits 24/7/365



Annual Wellness
Visit - Adults



Routine Preventive
Screenings -
Children & Adults



Routine Vision Exams
and Eyewear -
Children (Ages 0-18)



Preventive Prescription
Drugs



24-Hour Nurse
Advice Line

| | Molina Cascade Bronze | Molina Cascade Silver | | | | Molina Cascade Complete Gold | Molina Cascade Vital Gold |
|------------------------------------|-----------------------------|---------------------------------|---------------------------------|---------------------------------|--------------------------|------------------------------------|---------------------------------|
| | | Molina Cascade Silver 100 | Molina Cascade Silver 150 | Molina Cascade Silver 200 | Molina Cascade Silver | | |
| BENEFITS AND COST SHARE HIGHLIGHTS | | | | | | | |
| Deductible (Ind/Fam) | \$6,000 / \$12,000 | \$0 / \$0 | \$750 / \$1,500 | \$2,500 / \$5,000 | \$2,500 / \$5,000 | \$1,000 / \$2,000 | \$1,900 / \$3,800 |
| Drug Deductible (Ind/Fam) | Comb. w/Med | \$0 | Comb. w/Med | Comb. w/Med | Comb. w/Med | \$0 | Comb. w/Med |
| Out of Pocket Max (Ind/Fam) | \$10,150 / \$20,300 | \$2,400 / \$4,800 | \$2,850 / \$5,700 | \$7,950 / \$15,900 | \$9,750 / \$19,500 | \$7,000 / \$14,000 | \$8,800 / \$17,600 |
| Emergency Room Facility | 40% after ded | \$150 | \$425 after ded | \$800 after ded | \$800 after ded | \$450 after ded | \$800 after ded |
| Urgent Care Services | \$100 | \$15 | \$30 | \$65 | \$65 | \$35 | \$35 |

§ Mail-order is available for non-specialty drugs marked “MAIL” on the formulary. For mail-order Rx, a 90-day supply is provided at three times (3x) the 30-day retail cost-sharing amount. ① Cascade plans: For services with a co-pay that are subject to the deductible, the full amount of first-dollar out-of-pocket spending accrues toward the deductible. ② Eligible for two visits at \$1 copay, after which stated cost-sharing applies. This two-visit allowance is shared between Primary Care and Other Practitioner Care. ③ 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.

SERVICES WITHOUT
ANY DEDUCTIBLE

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| INPATIENT SERVICES | | | | | | | |
| Inpatient Facility Fee <i>*Professional Fees May Apply</i> | 40% after ded | \$100/day (max 5 copays) | \$425/day (max 5 copays) after ded | \$800/day (max 5 copays) after ded | \$800/day (max 5 copays) after ded | \$525/day (max 5 copays) | \$650/day (max 5 copays) after ded |
| OUTPATIENT PROFESSIONAL OFFICE VISITS SERVICES | | | | | | | |
| Primary Care | \$40 ② | \$1 ② | \$5 ② | \$20 ② | \$20 ② | \$15 | \$15 |
| Specialty Care | \$100 | \$15 | \$30 | \$65 | \$65 | \$40 | \$40 |
| Rehabilitative and Habilitative Services | 40% after ded | \$5 | \$20 | \$40 | \$40 | \$25 | \$30 |
| Mental / Behavioral Health Services / Substance Use Disorder Services | \$40 ③ | \$1 ③ | \$5 ③ | \$20 ③ | \$20 ③ | \$15 | \$15 |
| OUTPATIENT HOSPITAL FACILITY SERVICES | | | | | | | |
| Outpatient Facility Fee | 40% after ded | \$100 | \$325 after ded | \$600 after ded | \$600 after ded | \$350 after ded | \$350 after ded |
| Outpatient Professional Fee | 40% after ded | \$25 | \$120 after ded | \$200 after ded | \$200 after ded | \$75 after ded | \$75 after ded |
| Advanced Imaging and Specialized Scanning Services | 40% after ded | 15% | 20% after ded | 30% after ded | 30% after ded | \$300 after ded | \$300 after ded |
| Routine X- Ray and Diagnostic Services | 40% after ded | \$15 | \$40 | \$65 | \$65 | \$30 | \$30 |
| Laboratory Tests | 40% after ded | \$5 | \$20 | \$40 | \$40 | \$20 | \$30 |

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| PRESCRIPTION DRUGS [§] | | | | | | | |
| Preventive Drugs | No Charge | No Charge | No Charge | No Charge | No Charge | No Charge | No Charge |
| Preferred Generic Drugs | \$32 | \$5 | \$12 | \$24 | \$25 | \$10 | \$10 |
| Preferred Brand Drugs | 40% after ded | \$12 | \$35 | \$75 | \$75 | \$60 | \$75 |
| Non-Preferred Drugs | 40% after ded | \$35 | \$160 | \$250 after ded | \$250 after ded | \$100 | \$200 after ded |
| Specialty Drugs | 40% after ded | \$35 | \$160 | \$250 after ded | \$250 after ded | \$100 | \$200 after ded |

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