

Molina Healthcare of California: Molina Silver 70 HMO

Coverage Period: 01/01/2017 – 12/31/2017

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.molinahealthcare.com or by calling 1-888-858-2150.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual \$2,500 Family of 2 or more \$5,000 (Applies to IP, Emergency Room/Physician/Transport and Inpatient Services)	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes. Individual \$250 Family of 2 or more \$500 Prescription Drug Deductible (Applies to Preferred, Non-Preferred Brand & Specialty Drugs)	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$6,800 Individual \$13,600 Family of 2 or more	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 limit</u> ?	Premium and health care this plan doesn't cover.	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 Common Medical Events chart 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, go to www.molinahealthcare.com , or call 1-888-858-2150.	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?	Yes. All services except for females members to see an OB/GYN, family planning services, HIV testing and counseling, minor consent services, and services for sexually transmitted diseases.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services .

Questions: Call 1-888-858-2150 or visit us at www.molinahealthcare.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cms.gov/ccio/ or call 1-888-858-2150 to request a copy.

- **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 a Participating Provider	Your Cost If You Use an Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 Copay per visit	Not Covered	-----none-----
	Specialist visit	\$70 Copay per visit	Not Covered	Prior authorization may be required, or services not covered.
	Other practitioner office visit	\$35 Copay per visit	Not Covered	
If you have a test	Preventive care/screening/immunization	No Charge	Not Covered	-----none-----
	Diagnostic test (x-ray, blood work)	\$70 Copay – x-ray \$35 Copay -lab	Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$300 Copay	Not Covered	Prior authorization is required, or services not covered.
If you need drugs to treat your illness or condition	Generic drugs	\$15 Copay	Not Covered	-----none-----
	Preferred brand drugs	\$55 Copay	Not Covered	-----none-----
	Non-preferred brand drugs	\$80 Copay	Not Covered	-----none-----
More information about prescription drug coverage is available at www.molinhealthcare.com .	Specialty drugs	20% Coinsurance	Not Covered	Prior authorization is required, or services not covered. Up to \$250 per script after Pharmacy Deductible; Maximum Cost Sharing of \$200 for a 30-day supply of oral chemotherapy drugs , deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not Covered	Prior authorization may be required, or services not covered.
	Physician/surgeon fees	20% Coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	\$350 Copay per visit	\$350 Copay per visit	This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to "If you have a hospital stay", for applicable costs)
	Emergency medical transportation	\$250 Copay	\$250 Copay	-----none-----
	Urgent care	\$35 Copay per visit	\$35 Copay per visit	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not Covered	Prior authorization is required, or services not covered.
	Physician/surgeon fee	20% Coinsurance	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$35 Copay per visit (individual, group evaluation, counseling, intensive outpatient, day treatment programs)	Not Covered	Prior authorization may be required, or services not covered.
	Mental/Behavioral health inpatient services	20% Coinsurance	Not Covered	
	Substance use disorder outpatient services	\$35 Copay per visit (individual, group evaluation, counseling, intensive outpatient, day treatment programs)	Not Covered	
	Substance use disorder inpatient services	20% Coinsurance	Not Covered	
	Prenatal and postnatal care	No Charge	Not Covered	
If you are pregnant	Delivery and all inpatient services	20% Coinsurance	Not Covered	Prior notification is required, or services not covered. Pregnancy termination services are subject to restrictions and state law

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you need help recovering or have other special health needs</p>	Home health care	\$45 Copay	Not Covered	<p>Limited to:</p> <ul style="list-style-type: none"> Up to two (2) hours per visit for visits by a nurse, medical social worker, or physician, occupational, or speech therapist, and up to four (4) hours per visit by a home health aide Up to one-hundred (100) visits per calendar year (counting all home health visits) <p>Prior authorization is required, or services not covered.</p>
	Rehabilitation services	\$35 Copay per visit	Not Covered	Prior authorization is required, or services not covered.
	Habilitation services	\$35 Copay per visit	Not Covered	Prior authorization is required, or services not covered.
	Skilled nursing care	20% Coinsurance	Not Covered	<p>Limited to one-hundred (100) days per calendar year.</p> <p>Prior authorization is required, or services not covered.</p>
	Durable medical equipment	20% Coinsurance	Not Covered	Prior authorization is required for durable medical equipment over \$500, or services not covered.
	Hospice service	0% Coinsurance	Not Covered	Prior notification is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	-----none-----
	Glasses	\$0 Copay	Not Covered	Coverage limited to one pair of prescription eyeglasses (frames and lenses) or contact lenses in lieu of eyeglasses every 12 months. Greater quantities are available for certain kinds of contact lenses.
	Dental check-up	No Charge	Not Covered	Plan pays 100% preventive examinations twice per calendar year. See your policy or plan document for additional information about services.

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.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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
- Bariatric Surgery

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 1-888-858-2150. You may also contact your state insurance department at 1-888-466-2219.

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: 1-888-858-2150. Additionally, a consumer assistance program can help you file your appeal. Contact 1-888-466-2219.

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 [1-888-858-2150].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-888-858-2150].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [1-888-858-2150].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1-888-858-2150].]

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

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 \$4,040**
- 🕒 **Patient pays \$3,500**

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	\$2,000
Copays	\$420
Coinsurance	\$930
Limits or exclusions	\$150
Total	\$3,500

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

- 🕒 **Amount owed to providers: \$5,400**
- 🕒 **Plan pays \$2,210**
- 🕒 **Patient pays \$3,190**

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	\$2,000
Copays	\$1,050
Coinsurance	\$60
Limits or exclusions	\$80
Total	\$3,190

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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English: This notice has important information about your application or coverage with Molina Healthcare. You may need to take action by certain deadlines to keep your health coverage or help with costs. 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. Call Member Services at (888) 858-2150, or TTY 711 for the hearing impaired, Monday through Friday 8:00 a.m. - 6:00 p.m. PT.

Spanish: Este aviso contiene información importante acerca de su solicitud o cobertura con Molina Healthcare. Es posible que usted necesite tomar acción antes de determinadas fechas límites para poder conservar su cobertura de salud o recibir ayuda con los costos. 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. Comuníquese con nuestro Departamento de Servicios para Miembros al (888) 858-2150, o al servicio TTY al 711 para personas con impedimentos auditivos, de lunes a viernes, de 8:00 a. m. a 6:00 p. m., hora del Pacífico.

Chinese: 本通知提供了關於您申請 Molina Healthcare 或 Molina Healthcare 承保的重要資訊。您可能需要在某些截止日期前採取行動，保持您的健康承保或處理費用。有權因有特殊需要而要求提供這些資訊的不同格式（如音訊、盲文或大字體）或使用您的語言，且無需另付費用。請在星期一至星期五上午 8:00 至下午 6:00（太平洋時間）撥打 (888) 858-2150 或者 TTY 711（聽障人士專線）聯繫會員服務部。

Vietnamese: Thông báo này có thông tin quan trọng về đơn xin hoặc khoản bảo trả của quý vị với Molina Healthcare. Có thể có những ngày quan trọng trong thông báo này. Quý vị có thể cần hành động trước thời hạn nhất định để duy trì bảo hiểm y tế của quý vị hoặc để được trợ giúp với các khoản chi phí. Quý vị có quyền nhận thông tin này ở định dạng khác như âm thanh, hệ thống chữ Braille, hoặc phông chữ lớn do nhu cầu đặc biệt hoặc bằng ngôn ngữ của quý vị mà không chịu thêm khoản phát sinh chi phí nào. Quý vị cũng được cung cấp miễn phí dịch vụ thông dịch viên. Hãy gọi đến Dịch Vụ Thành Viên theo số (888) 858-2150, hoặc TTY 711 dành cho người khiếm thính, thứ Hai đến thứ Sáu, từ 8:00 giờ sáng - 6:00 giờ chiều, PT.

Tagalog: Ang abisong ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o pagkakasaklaw sa Molina Healthcare. Maaaring may kailangan kang isagawa bago ang ilang partikular na deadline upang mapanatili ang saklaw sa iyong kalusugan o ang tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito nang libre sa iba pang format, tulad ng audio, Braille o nang nakasulat sa malaking font dahil sa mga espesyal na pangangailangan o nang nakasulat sa iyong wika. Tawagan ang Member Services sa (888) 858-2150, o sa 711 kung gumagamit ng TTY para sa may kapansanan sa pandinig, Lunes hanggang Biyernes, 08:00 a.m. - 06:00 p.m. PT.

Korean: 본 통지문에는 귀하의 Molina Healthcare 신청 또는 보험에 대한 주요 정보가 포함되어 있습니다. 의료 보험 또는 비용 보조를 위해 특정 기한 내에 조치를 취해야 할 수 있습니다. 귀하는 특수한 상황에 따라 본 정보를 오디오, 점자, 큰 글씨 또는 귀하의 모국어 등의 다른 형태로 받아볼 권리가 있으며, 이 때 추가 비용은 없습니다. 청각 장애인의 경우, 월요일부터 금요일까지 오전 8시부터 오후 6시까지 (888) 858-2150번으로 회원 서비스에 전화하시거나 TTY 서비스 이용 시 711번으로 전화하시기 바랍니다.

Armenian: Այս ծանուցումը պարունակում է կարևոր տեղեկություններ դիմումի կամ Molina Healthcare ապահովագրական ծածկույթի մասին: Հնարավոր է, պետք լինի կոնկրետ ժամկետներում քայլեր ձեռնարկել՝ ձեր բժշկական ապահովագրությունը պահպանելու կամ ծախսերի հետ օգնելու հարցում: Դուք իրավունք ունեք ստանալ այս տեղեկատվությունը այլ ձևաչափով, օրինակ՝ աուդիո, Բրայլյան տառատեսակով կամ հատուկ խոշոր տառատեսակով, կամ ձեր լեզվով առանց լրացուցիչ ծախսերի: Չանգահարեք Հաճախորդների սպասարկման բաժին (888) 858-2150 հեռախոսով, կամ լսողության խնդիրներ ունեցող օգտվողները TTY 711, երկուշաբթիից ուրբաթ, 8:00-ից 18:00-ը, կադաղովկիանոյան ժամանակով:

Farsi: این اعلامیه اطلاعات مهمی درباره برنامه شما یا پوشش دهی با Molina Healthcare دارد. ممکن است لازم باشد در سررسیدهای مشخصی برای پوشش سلامت خود یا دریافت کمک از طریق پرداخت هزینه ها اقدام کنید. از این حق برخوردار هستید که این اطلاعات را در فرمت های مختلفی دریافت کنید، از جمله صدا، بریل یا فونت بزرگ به دلیل نیازهای خاص یا به زبان خود بدون دریافت هزینه اضافی. از طریق شماره (888) 858-2150 یا TTY 711 برای افرادی که دچار اختلالات شنوایی هستند، از دوشنبه تا جمعه ساعت 8:00 صبح تا 6:00 بعد از ظهر PT (زمان اقیانوس آرام) با خدمات اعضا تماس بگیرید.

Russian: В этом уведомлении содержится важная информация о вашей заявке или страховом покрытии, предоставляемом компанией Molina Healthcare. Это уведомление может содержать важные даты. Вам, возможно, потребуется предпринять некоторые действия до определенных сроков, чтобы сохранить страховое покрытие или получить помощь с оплатой. В связи с особыми потребностями вы имеете право бесплатно получить эту информацию на своем языке или в другом формате, включая крупный шрифт, шрифт Брайля или аудиоформат. Кроме того, вы можете бесплатно воспользоваться услугами переводчика. Обращайтесь в Отдел обслуживания участников по телефону (888) 858-2150 или 711 (линия TTY для лиц с нарушениями слуха) с понедельника по пятницу, с 8:00 до 18:00 по тихоокеанскому времени.

