

# SCHEDULE OF BENEFITS

## MOLINA HEALTHCARE OF IDAHO

### Molina Gold Core Zero Plus with Adult Dental and Vision

This Schedule of Benefits is intended to be used to help Members determine coverage of benefits and Cost Share. This Schedule of Benefits is a summary only. The Molina Healthcare of Idaho Agreement and Individual Evidence of Coverage (“Agreement”) should be consulted for additional description of benefit, limitation, and exclusion information.

This Plan does not include pediatric dental services as required under the Affordable Care Act. Pediatric dental service coverage is available through the Health Benefit Exchange and can be purchased as a stand-alone product.

In-network Deductible and Maximum Out-of-Pocket amounts accumulate separately from the Out-of-Network Deductible and Maximum Out-of-Pocket amounts. Members actual costs for services provided by an Out-of-Network provider may exceed this Plan’s Maximum Out-of-Pocket limit for Out-of-Network services. In addition, Out-of-Network providers can bill Members for the difference between the amount charged by the provider and the Molina’s Allowed Amount, and this amount is not counted toward the Out-of-Network Maximum Out-of-Pocket limit. Members should consult their Agreement or contact Molina Customer Support for additional information.

Benefit	At Participating Providers, You Pay	At Non-Participating Providers, You Pay
<b>Annual Medical Deductible per Calendar Year</b>	\$0 / \$0 (Individual/Family)	\$0 / \$0 (Individual/Family)
<b>Annual Prescription Drug Deductible per Calendar Year</b>	Combined with Medical Deductible	Combined with Medical Deductible
<b>Annual Out-of-Pocket Maximum per Calendar Year</b>	\$0 / \$0 (Individual/Family)	\$0 / \$0 (Individual/Family)
<b>Emergency and Urgent Care Services</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>
<b>Emergency Services</b>  <i>Note:</i> This cost does not apply if admitted directly to the hospital for inpatient services. Refer to “Inpatient Hospital Services” below for applicable Cost Sharing information.	No charge	No charge
<b>Emergency Medical Transportation (Ambulance)</b>	No charge	No charge
<b>Urgent Care Services</b> (must be provided by a Participating Provider facility)	No charge	No charge

*Note:* Please refer to the sections of the Agreement titled “Emergency Services” and “Urgent Care Services” for more information.

<b>Outpatient Professional Services</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>
<b>Primary Care Provider (PCP) and Other Practitioner Care Office Visit</b>	No charge	No charge
<b>Specialist Office Visit</b>	No charge	No charge
<b>Virtual Care provided by Teladoc Health</b>	No charge	No charge
<b>Preventive Care</b>  <i>Note: Please refer to the Agreement for full information of covered preventive services.</i>	No charge	No charge
<b>Mental/Behavioral Health Services Office Visit</b>	No charge	No charge
<b>Substance Use Disorder Services Office Visit</b>	No charge	No charge
<b>Mental Health Outpatient Services</b>	No charge	No charge
<b>Substance Use Disorder Outpatient Services</b>	No charge	No charge
<b>Habilitation and Rehabilitation Services</b> (All outpatient places of service)  <i>Note: There are no visit limits for treatment of Autism Spectrum Disorder or related diagnoses.</i>		
<b>Habilitative Services</b>	No charge	No charge
<b>Rehabilitative Services</b> <ul style="list-style-type: none"> <li>Limit 20 visits per calendar year or physical, occupational and speech therapy</li> </ul>	No charge	No charge
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>Limit 18 visits per calendar year</li> </ul>	No charge	No charge
<b>Outpatient Hospital / Facility Services</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>
<b>Outpatient Facility Fee</b>	No charge	No charge
<b>Outpatient Professional Fee</b>	No charge	No charge
<b>Accidental Dental</b>	No charge	No charge
<b>Specialized Scanning Services</b> (CT Scan, PET Scan, MRI).	No charge	No charge
<b>Radiology Services</b> (X-Rays)	No charge	No charge
<b>Laboratory Tests</b>	No charge	No charge
<b>Radiation</b>	No charge	No charge
<b>Cancer Chemotherapy and Other Provider-Administered Drugs</b>	No charge	No charge
<b>Inpatient Hospital Services</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>

<b>Facility Fee</b> <ul style="list-style-type: none"><li>Medical/Surgical</li><li>Maternity/Delivery</li><li>Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)</li></ul>	No charge	No charge
<b>Professional Physician/Surgeon Fee</b> <ul style="list-style-type: none"><li>Medical/Surgical,</li><li>Maternity</li><li>Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)</li></ul>	No charge	No charge
<b>Skilled Nursing Facility</b> <ul style="list-style-type: none"><li>Limit 30 days per calendar year</li></ul>	No charge	No charge
<b>Skilled Nursing Professional</b>	No charge	No charge
<b>Hospice</b>	No charge	No charge
<b>Prescription Drugs</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>
<b>Preferred Generic Drugs</b>	No charge	No charge
<b>Preferred Brand Drugs</b>	No charge	No charge
<b>Non-Preferred Drugs</b>	No charge	No charge
<b>Specialty Drugs</b>	No charge	No charge
<b>Preventive Drugs</b>	No charge	No charge
<b>Extended Day Supply</b>	Up to a 90-day supply is offered at three times the 30-day prescription Cost Sharing at network retail pharmacies or by mail order.	
<b>Note:</b> <ul style="list-style-type: none"><li>Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by the Member 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 the Member’s Plan.</li></ul>		
<b>Other Covered Services</b>	<b>At Participating Providers, You Pay</b>	<b>At Non-Participating Providers, You Pay</b>
<b>Durable Medical Equipment</b>	No charge	No charge
<b>Dialysis Services</b> <ul style="list-style-type: none"><li>Apply to facility charges only. This is outpatient cost sharing. For inpatient dialysis, inpatient facility Cost Sharing applies.</li></ul>	No charge	No charge
<b>Nutritional Counseling</b> <ul style="list-style-type: none"><li>Limit to 3 visits per calendar year</li></ul>	No charge	No charge

<b>Allergy Testing</b>	No charge	No charge
<b>Home Infusion</b> <ul style="list-style-type: none"> <li>Administration Only</li> </ul>	No charge	No charge
<b>Home Healthcare</b> <ul style="list-style-type: none"> <li>Services must be billed by a Home Healthcare agency that is a Participating Provider.</li> <li>Separate Cost Sharing may apply for other covered benefits delivered in the home setting, e.g. injectable drugs, durable medical equipment, etc.</li> </ul>	No charge	No charge
<b>Family Planning</b>	No charge	No charge

<b>Pediatric Vision Services (for Members under age 19 only)</b>	<b>At Participating Providers, You Pay</b>
<b>Comprehensive Vision Exam</b> <ul style="list-style-type: none"> <li>Limited to 1 each calendar year</li> </ul>	No charge
<b>Prescription Glasses</b> <b>Frames</b> <ul style="list-style-type: none"> <li>Limited to 1 pair of frames every calendar year</li> <li>Limited to a selection of covered frames</li> </ul> <b>Lenses</b> <ul style="list-style-type: none"> <li>Limited to 1 pair every calendar year</li> <li>Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses</li> <li>All lenses include scratch resistant coating and ultraviolet protection (UV)</li> </ul>	No charge
<b>Prescription Contact Lenses</b> <ul style="list-style-type: none"> <li>In lieu of prescription glasses, prescription contact lenses covered with a minimum 3-month supply for any of the following modalities every calendar year: <ul style="list-style-type: none"> <li>Standard (one pair annually)</li> <li>Monthly (six-month supply)</li> <li>Bi-weekly (three-month supply)</li> <li>Dailies (three-month supply)</li> </ul> </li> <li>Medically Necessary contact lenses for specified medical conditions require Prior Authorization.</li> </ul>	No charge
<b>Low Vision Optical Devices and Services</b> (Subject to limitations. Prior Authorization applies.)	No charge

<b>Adult Routine Vision Services (for Members age 19 and older)</b>	<b>At Participating Providers, You Pay</b>
<b>Services must be provided by a participating VSP provider.</b>	
<b>Comprehensive Vision Exam</b> <ul style="list-style-type: none"> <li>Limited to 1 each calendar year</li> </ul>	No charge
<b>Routine Retinal Screening</b>	\$39 Copayment
<b>Prescription Glasses</b> <i>Frames</i> <ul style="list-style-type: none"> <li>Limited to 1 pair of frames every calendar year (up to a \$150 allowance)</li> </ul> <i>Lenses</i> <ul style="list-style-type: none"> <li>Limited to 1 pair every calendar year</li> <li>Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses</li> </ul>	No charge
<b>Prescription Contact Lenses</b> <ul style="list-style-type: none"> <li>In lieu of prescription glasses, materials and services are limited to 1 pair of contact lenses up to \$150 every calendar year.</li> </ul> <p>Medically Necessary contact lenses for specified medical conditions require Prior Authorization.</p>	No charge

<b>Adult Dental Services (for Members age 19 and older)</b>	<b>At Participating Providers, You Pay</b>
All dental services are subjected to an annual maximum of \$1,000 per Plan year. No services are subject to a Deductible.	
<b>Diagnostic &amp; Preventive</b> (Limited to 1 every 6 months)	No charge
<b>Basic Dental Services</b>	50% Coinsurance
<b>Major Dental Services</b> (Available after 6 consecutive months of enrollment)	50% Coinsurance
<b>Orthodontics</b> Medically necessary orthodontics and accidental dental are covered under Medical benefits.	Not Covered
Waiting Periods are calculated for each Adult Enrollee from the effective date of coverage reported by the Exchange for said Adult Enrollee. Prior coverage for Adult Enrollees under any Delta Dental Exchange plan that included an adult Waiting Period will be credited towards the adult Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.	