SCHEDULE OF BENEFITS

MOLINA HEALTHCARE OF IDAHO

Molina Gold Core 1640 LCS Plus with Adult 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
Annual Medical Deductible per Calendar Year	$1640 / $3280 (Individual/Family)	$20300 / $40600 (Individual/Family)
Annual Prescription Drug Deductible per Calendar Year	Combined with Medical Deductible	Combined with Medical Deductible
Annual Out-of-Pocket Maximum per Calendar Year	$8100 / $16200 (Individual/Family)	$101500 / $203000 (Individual/Family)
Emergency and Urgent Care Services	**At Participating Providers, You Pay**	**At Non-Participating Providers, You Pay**
Emergency Services *Note:* 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.	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Emergency Medical Transportation (Ambulance)	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Urgent Care Services (must be provided by a Participating Provider facility)	$40 Copayment per visit	60% Coinsurance after Deductible
Note: Please refer to the sections of the Agreement titled "Emergency Services" and "Urgent Care Services" for more information.		

Outpatient Professional Services	At Participating Providers, You Pay	At Non-Participating Providers, You Pay
Primary Care Provider (PCP) and Other Practitioner Care Office Visit	$25 Copayment per visit	60% Coinsurance after Deductible
Specialist Office Visit	$55 Copayment per visit	60% Coinsurance after Deductible
Virtual Care provided by Teladoc Health	No charge	60% Coinsurance after Deductible
Preventive Care *Note*: Please refer to the Agreement for full information of covered preventive services.	No charge	60% Coinsurance after Deductible
Mental/Behavioral Health Services Office Visit	$25 Copayment per visit	60% Coinsurance after Deductible
Substance Use Disorder Services Office Visit	$25 Copayment per visit	60% Coinsurance after Deductible
Mental Health Outpatient Services	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Substance Use Disorder Outpatient Services	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Habilitation and Rehabilitation Services (All outpatient places of service) *Note*: There are no visit limits for treatment of Autism Spectrum Disorder or related diagnoses.		
Habilitative Services	$25 Copayment per visit	60% Coinsurance after Deductible
Rehabilitative Services • Limit 20 visits per calendar year or physical, occupational and speech therapy	$25 Copayment per visit	60% Coinsurance after Deductible
Chiropractic Services • Limit 18 visits per calendar year	$25 Copayment per visit	60% Coinsurance after Deductible
Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	**At Non-Participating Providers, You Pay**
Outpatient Facility Fee	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Outpatient Professional Fee	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Accidental Dental	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Specialized Scanning Services (CT Scan, PET Scan, MRI).	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Radiology Services (X-Rays)	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Laboratory Tests	$25 Copayment	60% Coinsurance after Deductible
Radiation	25% Coinsurance after Deductible	60% Coinsurance after Deductible

Cancer Chemotherapy and Other Provider-Administered Drugs	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Inpatient Hospital Services	**At Participating Providers, You Pay**	**At Non-Participating Providers, You Pay**
Facility Fee • Medical/Surgical • Maternity/Delivery • Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Professional Physician/Surgeon Fee • Medical/Surgical, • Maternity • Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Skilled Nursing Facility • Limit 30 days per calendar year	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Skilled Nursing Professional	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Hospice	No charge	60% Coinsurance after Deductible
Prescription Drugs	**At Participating Providers, You Pay**	**At Non-Participating Providers, You Pay**
Preferred Generic Drugs	$15 Copayment	60% Coinsurance after Deductible
Preferred Brand Drugs	$50 Copayment after Deductible	60% Coinsurance after Deductible
Non-Preferred Drugs	30% Coinsurance after Deductible	60% Coinsurance after Deductible
Specialty Drugs	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Preventive Drugs	No charge	60% Coinsurance after Deductible
Extended Day Supply	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.	
Note: • 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.		

Other Covered Services	At Participating Providers, You Pay	At Non-Participating Providers, You Pay
Durable Medical Equipment	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Dialysis Services • Apply to facility charges only. This is outpatient cost sharing. For inpatient dialysis, inpatient facility Cost Sharing applies.	$55 Copayment	60% Coinsurance after Deductible
Nutritional Counseling • Limit to 3 visits per calendar year	No charge	60% Coinsurance after Deductible
Allergy Testing	$25 Copayment per visit	60% Coinsurance after Deductible
Home Infusion • Administration Only	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Home Healthcare • 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.	25% Coinsurance after Deductible	60% Coinsurance after Deductible
Family Planning	No charge	60% Coinsurance after Deductible

Pediatric Vision Services (for Members under age 19 only)	At Participating Providers, You Pay
Comprehensive Vision Exam • Limited to 1 each calendar year	No charge
Prescription Glasses *Frames* • Limited to 1 pair of frames every calendar year • Limited to a selection of covered frames *Lenses* • Limited to 1 pair 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
• In lieu of prescription glasses, prescription contact lenses covered with a minimum 3-month supply for any of the following modalities every calendar year:
  ○ Standard (one pair annually)
  ○ Monthly (six-month supply)
  ○ Bi-weekly (three-month supply)
  ○ Dailies (three-month supply)
• Medically Necessary contact lenses for specified medical conditions require Prior Authorization.
	No charge

Low Vision Optical Devices and Services (Subject to limitations. Prior Authorization applies.)	No charge

Adult Routine Vision Services (for Members age 19 and older)	**At Participating Providers, You Pay**
Services must be provided by a participating VSP provider.	
Comprehensive Vision Exam • Limited to 1 each calendar year	No charge
Routine Retinal Screening	$39 Copayment
Prescription Glasses *Frames* • Limited to 1 pair of frames every calendar year (up to a $150 allowance) *Lenses* • Limited to 1 pair every calendar year • Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses	No charge
Prescription Contact Lenses • In lieu of prescription glasses, materials and services are limited to 1 pair of contact lenses up to $150 every calendar year. Medically Necessary contact lenses for specified medical conditions require Prior Authorization.	No charge