# SCHEDULE OF BENEFITS

## Molina Healthcare of Illinois, Inc.
## Molina Silver Saver 70 with Four Free PCP or MH Visits

**THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE ("AGREEMENT") SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.**

In general, a Member must receive Covered Services from Participating Providers; otherwise, the services are not covered, the Member will be 100% responsible for payment to the Non- Participating Provider, and the payments will not apply to the Deductible or Annual Out-of-Pocket Maximum. Molina will pay an "Allowed Amount" (sometimes referred to as "Recognized Amount"), which is the maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing. However, a Member may receive services from a Non-Participating Provider for Emergency Services and for exceptions described in the section of the Agreement titled "Access to Care." For more details, please see the Agreement.

**No Surprises Act Notice:** When you get certain Covered Services from Non-Participating Providers (Emergency Services, Post-Stabilization Services, air ambulance services, or Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law), you are protected from Surprise Billing or Balance Billing. You are only responsible for paying your applicable Cost Sharing (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was a Participating Provider. Molina will pay the Non-Participating providers and facilities directly for these Covered Services. See your Agreement for further details.

| Benefit | At Participating Providers, You Pay |
|---|---|
| **Annual Medical Deductible per Calendar Year** | $7,000 / $14,000 (Individual/Family) |
| **Annual Pharmacy Deductible per Calendar Year** | Combined with Medical Deductible |
| **Annual Out-of-Pocket Maximum per Calendar Year**<br><br>*Note*: Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to your Annual Out-of-Pocket Maximum. | $10,150 / $20,300 (Individual/Family) |

| Outpatient Professional Services | At Participating Providers, You Pay |
|---|---|
| **Primary Care Provider (PCP) and Other Practitioner Care Office Visit** | $40 Copayment per visit |
| **Specialist Office Visit** | $62.50 Copayment per visit |
| **Virtual Care provided by Teladoc Health** | No charge |
| **Preventive Care** (including screenings, immunizations and well-baby visits) | No charge |
| **Mental/Behavioral Health Services** (including Autism Spectrum Disorder) | $40 Copayment per visit |
| **Substance Use Disorder Services** | $40 Copayment per visit |
| **Habilitative Services**<br>• Member cost-shares shown apply in any place of service.<br>• Treatment must be medically necessary and therapeutic and not investigational. | 20% Coinsurance after Deductible |
| **Rehabilitative Services**<br>• Maintenance therapies are not covered. | 20% Coinsurance after Deductible |
| *Notes*: *Office Visits (Includes Telehealth)*<br>• If you are seen in a hospital-based clinic, outpatient hospital Cost Sharing will apply to facility and ancillary charges. Associated professional fees, limited to Evaluation and Management (E&M) services, will be processed assessing your PCP or Specialist Cost Sharing.<br>• For laboratory and diagnostic X-ray services that are provided in a PCP's or Specialist Physician's office, on the same date of service as a PCP or Specialist Physician office visit, you will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and X-ray Cost Sharing, as shown in the Schedule of Benefits, will apply if services are provided by a Participating Provider at a separate location, even if on the same day as an office visit. | |
| **Outpatient Facility Services** | **At Participating Providers, You Pay** |
| **Outpatient Facility** | 20% Coinsurance after Deductible |
| **Outpatient Surgery Physician/Surgical Services** | 20% Coinsurance after Deductible |

| Outpatient Hospital / Facility Services | At Participating Providers, You Pay | |
|---|---|---|
| **Laboratory Tests** | 20% Coinsurance after Deductible | |
| **Radiology Services** (e.g., X-Rays) | 20% Coinsurance after Deductible | |
| **Specialized Scanning Services** (e.g., CT Scan, PET Scan, MRI)<br><br>*Note: Unless Specialized Scanning Services are performed while you are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.* | 20% Coinsurance after Deductible | |
| **Dental Services Related to Accidental Injury** | 20% Coinsurance after Deductible | |
| **Cancer Chemotherapy and Other Provider Administered Drugs** | 20% Coinsurance after Deductible<br>(Cost Sharing applies to professional/administration fees, and the associated drug) | |
| **Prescription Drugs** | **At Participating Providers, You Pay** | |
| **Preferred Generic Drugs** | $5 Copayment | |
| **Preferred Brand Drugs** | $100 Copayment | |
| **Non-Preferred Brand and Generic Drugs** | 20% Coinsurance after Deductible | |
| **Specialty Drugs** | 20% Coinsurance after Deductible | |
| **Preventive Drugs** | No charge | |
| **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. | |
| **Emergency and Urgent Care Services** | **At Participating Providers, You Pay** | **At Non-Participating Providers, You Pay** |
| Emergency Services<br>*Note:* This cost does not apply if admitted directly to the hospital for inpatient services. | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible |
| Emergency Medical Transportation (Ground Ambulance or Air Ambulance)<br>• Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible |
| Urgent Care Services (must be provided by a Participating Provider) | $60 Copayment per visit | Not Covered |
| Upon reasonable demand by a provider of Emergency Medical Transportation by ambulance, Molina shall promptly pay to the provider, subject to coverage limitations stated in this Agreement, the charges for Emergency Medical Transportation by ambulance provided to Member arranged for by the Molina. By accepting any such payment from the Molina, the provider of Emergency Medical Transportation by ambulance agrees not to seek any payment from the Member for services provided to the Member. | | |

| Inpatient hospital services | At participating providers, you pay |
|---|---|
| **Facility Fee (e.g., hospital room)**<br>• Medical/Surgical<br>• Maternity Care<br>• Mental/Behavioral Health Services<br>• Substance Use Disorder | 20% Coinsurance after Deductible |
| **Professional Physician/Surgeon Fee** | 20% Coinsurance after Deductible |
| **Rehabilitation Services**<br>• Maintenance therapies are not covered | 20% Coinsurance after Deductible |
| **Skilled Nursing Facility**<br>• Services must be billed by a Skilled Nursing Facility Participating Provider | 20% Coinsurance after Deductible |
| **Hospice Care** (includes out-of-network coverage) | No charge |
| **Other Covered Services** | **At Participating Providers, You Pay** |
| **Durable Medical Equipment** | 20% Coinsurance after Deductible |
| **Hearing Aids**<br>• Limited to one hearing aid per Member per ear every 36 months | 20% Coinsurance after Deductible |
| **Home Health Care**<br>• Private Duty Nursing<br>• Limited to 100 visits | 20% Coinsurance after Deductible |
| **Dialysis Services** | $62.50<br>Copayment<br>per visit |
| **Treatment for Temporomandibular Joint Disorders** (Medically Necessary surgical and arthroscopic treatment) | 20% Coinsurance after Deductible |
| **Family Planning** | No charge |

| Pediatric Vision Services (for Members under age 19 only) | At Participating Providers, You Pay |
|---|---|
| **Comprehensive Vision Exam**<br>• Limited to 1 each calendar year | No charge |
| **Prescription Glasses**<br>*Frames*<br>• Limited to 1 pair of frames every calendar year<br>• Limited to a selection of covered frames<br>*Lenses*<br>• Limited to 1 pair every calendar year<br>• Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses<br>• All lenses include scratch resistant coating and ultraviolet protection (UV)<br><br>Includes one pair of replacement eyeglasses every 12 months or repair of lenses and/or frames when Medically Necessary. | No charge |
| **Prescription Contact Lenses**<br>• In lieu of prescription glasses, prescription contact lenses covered with a minimum 3-month supply for any of the following modalities every calendar year:<br>o Standard (one pair annually)<br>o Monthly (six-month supply)<br>o Bi-weekly (three-month supply)<br>o Dailies (three-month supply)<br><br>Medically Necessary contact lenses for specified medical conditions require Prior Authorization. | No charge |
| **Low Vision Optical Devices and Services**<br>(Subject to limitations. Prior Authorization applies.) | No charge |