SCHEDULE OF BENEFITS

Molina Healthcare of Illinois, Inc.
Molina Gold Core Zero Plus with Rx Copay and Adult Dental and Vision

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	$0 / $0 (Individual/Family)
Annual Pharmacy Deductible per Calendar Year	Combined with Medical Deductible
Annual Out-of-Pocket Maximum per Calendar Year *Note*: Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to your Annual Out-of-Pocket Maximum.	$0 / $0 (Individual/Family)

Outpatient Professional Services	At Participating Providers, You Pay
Primary Care Provider (PCP) and Other Practitioner Care Office Visit	No charge
Specialist Office Visit	No charge
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)	No charge
Substance Use Disorder Services	No charge
Habilitative Services • Member cost-shares shown apply in any place of service. • Treatment must be medically necessary and therapeutic and not investigational.	No charge
Rehabilitative Services • Maintenance therapies are not covered.	No charge
Notes: *Office Visits (Includes Telehealth)* • 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. • 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	No charge
Outpatient Surgery Physician/Surgical Services	No charge
Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**
Laboratory Tests	No charge
Radiology Services (e.g., X-Rays)	No charge
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI) *Note: Unless Specialized Scanning Services are performed while you are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.*	No charge
Dental Services Related to Accidental Injury	No charge
Cancer Chemotherapy and Other Provider Administered Drugs	No charge (Cost Sharing applies to professional/administration fees, and the associated drug)

Prescription Drugs	At Participating Providers, You Pay
Preferred Generic Drugs	No charge
Preferred Brand Drugs	No charge
Non-Preferred Brand and Generic Drugs	No charge
Specialty Drugs	No charge
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 *Note:* This cost does not apply if admitted directly to the hospital for inpatient services.	No charge	No charge
Emergency Medical Transportation (Ground Ambulance or Air Ambulance) • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers	No charge	No charge
Urgent Care Services (must be provided by a Participating Provider)	No charge	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) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder	No charge
Professional Physician/Surgeon Fee	No charge
Rehabilitation Services • Maintenance therapies are not covered	No charge
Skilled Nursing Facility • Services must be billed by a Skilled Nursing Facility Participating Provider	No charge
Hospice Care (includes out-of-network coverage)	No charge

Other Covered Services	At Participating Providers, You Pay
Durable Medical Equipment	No charge
Hearing Aids • Limited to one hearing aid per Member per ear every 36 months	No charge
Home Health Care • Private Duty Nursing • Limited to 100 visits	No charge
Dialysis Services	No charge
Treatment for Temporomandibular Joint Disorders (Medically Necessary surgical and arthroscopic treatment)	No charge
Family Planning	No charge
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) Includes one pair of replacement eyeglasses every 12 months or repair of lenses and/or frames when Medically Necessary.	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: o Standard (one pair annually) o Monthly (six-month supply) o Bi-weekly (three-month supply) o 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

Adult Dental Services (for Members age 19 and older)	At Participating Providers, You Pay
All dental services are subjected to an annual maximum of $1,000 per Plan year. No services are subject to a Deductible.	
Diagnostic & Preventive (Limited to 1 every 6 months)	No charge
Basic Dental Services	No charge
Major Dental Services (Available after 6 consecutive months of enrollment)	No charge
Orthodontics 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.	