SCHEDULE OF BENEFITS

Molina Healthcare of Nevada, Inc.
Molina Gold Core LCS Plus with Adult 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.

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE, YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PRODUCT FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

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	$1640 / $3280 (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.	$8100 / $16200 (Individual/Family)
Outpatient Professional Services	**At Participating Providers, You Pay**
Primary Care Provider (PCP) and Other Practitioner Care Office Visit	$25 Copayment per visit
Specialist Office Visit	$55 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)	$25 Copayment per visit
Substance Use Disorder Services	$25 Copayment per visit
Habilitative Services • Member cost-share applies in any place of service. All Inpatient and Outpatient short-term habilitative services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year.	$25 Copayment per visit
Rehabilitative Services • Member cost-share applies in any place of service. • All Inpatient and Outpatient short-term habilitative services are subject to a combined maximum benefit of one hundred twenty (120) days/visits per Member per Calendar Year. • Stuttering therapy is covered under speech therapy with no age or coverage limits up to age 26.	$25 Copayment per visit

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	25% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	25% Coinsurance after Deductible

Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**
Laboratory Tests	$25 Copayment
Radiology Services (e.g., X-Rays)	25% Coinsurance after Deductible
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.*	25% Coinsurance after Deductible
Dental Services Related to Accidental Injury	25% Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs	40% Coinsurance after Deductible (Cost Sharing applies to professional/administration fees, and the associated drug)
Prescription Drugs	**At Participating Providers, You Pay**
Preferred Generic Drugs	$15 Copayment
Preferred Brand Drugs	$50 Copayment after Deductible
Non-Preferred Brand and Generic Drugs	30% Coinsurance after Deductible
Brand and Generic Specialty Drugs	40% 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.

Notes:
Cost-sharing for insulin is capped at $35 per 30-day supply of each prescription insulin drug.

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.	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Emergency Medical Transportation (Ground Ambulance or Air Ambulance) *Note:* Ground Ambulance transportation may be subject to Balance Billing. Members may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for services rendered by a Non-Participating Provider.	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Urgent Care Services (must be provided by a Participating Provider)	$40 Copayment per visit	Not Covered

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	25% Coinsurance after Deductible
Professional Physician/Surgeon Fee	25% Coinsurance after Deductible
Skilled Nursing Facility • Limited to 100 days per calendar year • Services must be billed by a Skilled Nursing Facility Participating Provider	25% Coinsurance after Deductible
Hospice Care • Respite care is limited to 5 days/visits per 90 days of home hospice and bereavement services are limited to 5 group therapy sessions per episode	No charge
Other Covered Services	**At Participating Providers, You Pay**
Durable Medical Equipment • Limited to one item per Member per every 36 months, including Prosthetic, Orthotic, Internal Implanted and External Devices.	25% Coinsurance after Deductible
Home Health Care	25% Coinsurance after Deductible
Dialysis Services	$55 Copayment
Treatment for Temporomandibular Joint Disorders (Medically Necessary surgical and arthroscopic treatment)	25% Coinsurance after Deductible
Infertility Treatment • Covered services include office visit evaluation limited laboratory studies, diagnostic procedures and up to six (6) cycles of artificial insemination services per Member per lifetime.	$55 Copayment

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