SCHEDULE OF BENEFITS

MOLINA HEALTHCARE OF UTAH, INC.

Molina Silver Core 87 Plus with Adult Vision

The Schedule of Benefits below is intended to help Members determine benefits coverage and is a summary only. The Molina Healthcare of Utah, Inc. Agreement and Individual Evidence of Coverage should be consulted for a detailed description of benefits, limitations, and exclusions.

Notice: This Plan does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. Pediatric dental coverage is available in the Exchange. Please contact your insurance carrier, agent, or Federally Facilitated Marketplace if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

In general, Members must receive Covered Services from Participating Providers; otherwise, the services are not covered, Members will be 100% responsible for payment to the Non-Participating Provider and the payments will not apply to the Member's Deductible or Annual Maximum Out-of-Pocket. However, Members may receive services from a Non-Participating Provider for Emergency Services, Post-Stabilization, Urgent Care Services, and for exceptions described in the section of the Agreement titled "No Participating Provider to Provide a Covered Service".

Benefit	At Participating Providers, You Pay	
Annual Medical Deductible per Calendar Year	$850 / $1700 (Individual/Family)	
Annual Prescription Drug 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.	$3050 / $6100 (Individual/Family)	
Emergency and Urgent Care Services	**At Participating Providers, You Pay**	**At Non-Participating Providers, You Pay**
Emergency Services *Note:* Please refer to the section of the Agreement titled "Emergency Services" for more information. Cost Sharing waived if admitted directly to the hospital for inpatient services. Inpatient Cost Sharing applies if admitted. Refer to "Inpatient Hospital Services" for applicable Cost Sharing information.	35% Coinsurance after Deductible	35% Coinsurance after Deductible

Emergency Medical Transportation (Ambulance) *Note:* Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.	35% Coinsurance after Deductible	35% Coinsurance after Deductible
Urgent Care Services (must be provided by a Participating Provider facility)	$25 Copayment per visit	Not Covered
Outpatient Professional Services	**At Participating Providers, You Pay**	
Primary Care Provider (PCP) and Other Practitioner Care Office Visit	$8 Copayment per visit	
Specialist Office Visit	$30 Copayment per visit	
Virtual Care provided by Teladoc Health	No Charge	
Preventive Care (Including prenatal and first postpartum exam)	No Charge	
Mental/Behavioral Health Services	$8 Copayment per visit	
Substance Use Disorder Services	$8 Copayment per visit	
Habilitative and Rehabilitative Services • Habilitative and Rehabilitative Services benefits each separately have a limit of 20 visits per calendar year. Member Cost Sharing and visit limits shown apply in any place of service.	$35 Copayment per visit	
Phenylketonuria (PKU)		
Preventive Care Screening for Children	No Charge	
Testing and Treatment of PKU	$8 Copayment per visit	
Note: • If Members are seen in a hospital-based clinic, outpatient hospital Cost Sharing may apply to facility and ancillary charges. Associated professional fees, limited to Evaluation and Management (E&M) services will be processed assessing Member's PCP or Specialist Cost Sharing. • For laboratory and diagnostic X-ray services that are provided in a PCP's or Specialist's office, on the same date of service as a PCP or Specialist office visit, Members 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 Services	**At Participating Providers, You Pay**	

Medical Outpatient Professional & Facility • Outpatient Surgery • Outpatient Non-Surgical Services **Mental / Behavioral Health / Substance Abuse** • Outpatient Intensive Psychiatric Treatment Programs **Infertility Services** • Exploratory procedures to correct diagnosed disease or condition of the reproductive organs	
Facility	35% Coinsurance after Deductible
Professional	35% Coinsurance after Deductible
Chemotherapy Services and Provider-Administered Drug	50% Coinsurance after Deductible
Radiation Services	35% Coinsurance after Deductible
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI). *Note:* For laboratory and diagnostic X-ray services that are provided in a PCP's or Specialist's office, on the same date of service as a PCP or Specialist office visit, Member's 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.	35% Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	$80 Copayment
Laboratory Tests	$40 Copayment
Inpatient Hospital Services	**At Participating Providers, You Pay**
Medical/Surgical	
Facility Fee (e.g., hospital room) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services (Inpatient Psychiatric Hospitalization) • Substance Use Disorder (Transitional Residential Recovery and Services Inpatient Detoxification)	35% Coinsurance after Deductible
Professional Physician/Surgeon Fee	35% Coinsurance after Deductible
Skilled Nursing Facility • Limited to 30 days per calendar year • Services must be billed by a Skilled Nursing Facility Participating Provider.	35% Coinsurance after Deductible
Hospice Care • Limited to 6 months per 3 calendar year	No Charge

Prescription Drugs	At Participating Providers, You Pay
Preferred Generic Drugs	$5 Copayment
Preferred Brand Drugs	$65 Copayment
Non-Preferred Drugs	40% Coinsurance after Deductible
Specialty Drugs	50% 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.
Note: • For details, please refer to the Agreement section titled "Prescription Drugs." Cost Sharing reduction for any prescription drugs obtained by Members 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. • There are limits on your cost sharing for insulin. The $10 limit applies per insulin drug, per 30-day supply. The limit does not apply to products that contain other drugs besides insulin.	
Ancillary and Other Services	**At Participating Providers, You Pay**
Durable Medical Equipment	35% Coinsurance after Deductible
Home Health Care • Limit of 30 visits per calendar year • Services must be billed by a Home Healthcare Participating Provider agency	35% Coinsurance after Deductible
Dialysis Services • Apply to facility charges only. This is outpatient cost sharing. For inpatient dialysis, inpatient hospital cost sharing applies	$30 Copayment
Adoption Indemnity Benefit • If more than one child from the same birth is placed for adoption with the Subscriber, only one adoption indemnity benefit will be paid. Please refer to the Adoption Benefits section of the Agreement for a description of adoption benefits and restrictions.	$4,000 per Adoption

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: 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

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