MOLINA HEALTHCARE OF FLORIDA, INC.
SCHEDULE OF BENEFITS
Marketplace – Silver 9 150

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF FLORIDA, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE 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. 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."

IMPORTANT NOTE: This plan uses "benefit tiering." Tiered benefits are designed to help members make smarter choices, including how much they will spend when receiving certain healthcare services. With a tiered benefit plan, your out-of-pocket costs are determined by which network tier the Participating Hospital/Facility is in. This plan two benefit tiers for certain participating Hospitals and Facilities:

- *Choice Hospital/Facility Network ("Choice Network")* – you will save the most money at these Participating Hospitals/Facilities. Choice Network includes Hospitals/Facilities that will provide services at lower plan cost-sharing for the member.
- *Select Hospital/Facility Network ("Select Network")* – you will pay more out-of-pocket costs at these Participating Hospitals/Facilities. Select Network includes Hospitals/Facilities that will provide services at a higher plan cost-sharing for the member.

Deductible Type	At Participating Providers, You Pay
Medical Deductible	
Individual	$700
Entire Family of 2 or more Members	$1,400
Prescription Drug Deductible	
Individual	Combined with Medical Deductible
Entire Family of 2 or more Members	Combined with Medical Deductible
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$2,775
Entire Family of 2 or more	$5,550

[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to your Annual Out-of-Pocket Maximum.

Emergency Services and Urgent Care Services[2]	You Pay	
Emergency Services[3]	25%	Coinsurance after Deductible
Urgent Care Services (Services must be provided by a Participating Provider facility.)	$20	Copayment per visit

[2] Please refer to the sections of the Agreement titled "Emergency Services" and "Urgent Care Services" for more information.

[3] 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.

Outpatient Professional Services[4]	At Participating Providers, You Pay	
Office Visits[5]		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care (PCP) and Other Practitioner Care	$9	Copayment per visit
Specialty Care	$30	Copayment per visit
Habilitative Services	$9	Copayment per visit
Rehabilitative Services[6]	$9	Copayment per visit
Mental/Behavioral Health Services	$9	Copayment per visit
Substance Abuse Disorder Services	$9	Copayment per visit
Dental Services Related to Accidental Injury	25%	Coinsurance after Deductible
Family Planning	No Charge	

[4] Please note, 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.

[5] 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.

[6] Outpatient rehabilitative services are limited to a total of 35 visits for any combination of physical therapy, occupational therapy, speech therapy, cardiac rehabilitation therapy, massage therapy by a licensed massage therapist, and spinal manipulative therapy. Only 26 of those visits can be for spinal manipulative therapy.

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

Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Outpatient Surgical and Non-Surgical Services – including Outpatient Intensive Psychiatric Treatment Programs		
Professional	25%	Coinsurance after Deductible
Facility	*Choice Hospital/Facility Network:* 25% *Select Hospital/Facility Network:* 50%	Coinsurance after Deductible
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)[7]	*Choice Hospital/Facility Network:* 25% *Select Hospital/Facility Network:* 50%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	*Choice Hospital/Facility Network:* $65 *Select Hospital/Facility Network:* $130	Copayment
Laboratory Tests	*Choice Hospital/Facility Network:* $25 *Select Hospital/Facility Network:* $50	Copayment

[7] Unless Specialized Scanning Services are performed while you are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.

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	*Choice Hospital/Facility Network:* 25% *Select Hospital/Facility Network:* 50%	Coinsurance after Deductible
Professional Physician/Surgeon Fee	25%	Coinsurance after Deductible
Skilled Nursing Facility[8] (Limited to 60 days per calendar year)	*Choice Hospital/Facility Network:* 25% *Select Hospital/Facility Network:* 50%	Coinsurance after Deductible
Hospice Care	No Charge	

[8] Services must be billed by a Skilled Nursing Facility Participating Provider.

Prescription Drug Coverage[9]	At Participating Providers, You Pay	
Preventive Drugs	No Charge	
Preferred Generic Drugs	$5	Copayment
Preferred Brand Drugs	$65	Copayment
Non-Preferred Drugs	25%	Coinsurance after Deductible
Specialty Drugs	25%	Coinsurance after Deductible
Mail-Order Prescription Drugs	Up to a 90-day supply is offered at two-and-a-half times the 30-day prescription Cost Sharing.	

[9] For details, please refer to the Agreement section titled "Prescription Drugs." Please note, Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by you 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 your Plan.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	25%	Coinsurance after Deductible
Home Health Care[10] (Limited to 60 visits per calendar year)	No Charge	

[10] Services must be billed by a Home Healthcare Participating Provider agency. Separate Cost Sharing may apply for other Covered Services delivered in the home setting (e.g., injectable drugs).

Emergency Medical Transportation	You Pay	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered; however, You may be responsible for provider charges that exceed the allowed amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.)	25%	Coinsurance after Deductible, plus amounts that exceed the Allowed Amount

Other Services	At Participating Providers, You Pay	
Dialysis Services	$30	Copayment