Passport by Molina Healthcare
SCHEDULE OF BENEFITS
Marketplace – Constant Care Silver 1 100

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE PASSPORT 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. Passport will pay an "Allowed Amount" (sometimes referred to as "Recognized Amount"), which is the maximum amount that Passport 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. Passport will pay the Non-Participating providers and facilities directly for these Covered Services. See your Agreement for further details.

Deductible Type	At Participating Providers, You Pay
Medical Deductible	
Individual	$0
Entire Family of 2 or more Members	$0
Prescription Drug Deductible	
Individual	$0
Entire Family of 2 or more Members	$0
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$1,400
Entire Family of 2 or more	$2,800

[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, 4]	$350	Copayment per visit
Urgent Care Services (Services must be provided by a Participating Provider facility.)	$0	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.

[4] Includes out-of-network coverage.

Outpatient Professional Services[5]	At Participating Providers, You Pay	
Office Visits[6, #]		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care (PCP) and Other Practitioner Care	$0	Copayment per visit
Specialty Care	$10	Copayment per visit
Habilitative Services • Physical Therapy, Occupational Therapy, Speech Therapy – limit of 25 visits per therapy per calendar year. These limits do not apply to services for Autism.	$0	Copayment per visit
Rehabilitative Services • Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Therapy – limit of 25 visits per therapy per calendar year • Cardiac Rehabilitation – limit of 36 visits per calendar year • Manipulation Therapy – limit of 20 visits per calendar year • Post-Cochlear Implant Aural Therapy – limit of 30 visits per calendar year • Cognitive Rehabilitation Therapy – limit of 30 visits per calendar year	$0	Copayment per visit
Mental/Behavioral Health Services[#] • Including Autism Spectrum Disorder	$0	Copayment per visit
Substance Abuse Disorder Services[#]	$0	Copayment per visit
Dental Services Related to Accidental Injury	25%	Coinsurance
Treatment for Temporomandibular Joint Disorders (Medically Necessary surgical and arthroscopic treatment)	25%	Coinsurance
Family Planning	No Charge	

[5] 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.

[6] 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.

[#] Includes telehealth services.

Pediatric Vision Services (for Members under age 21 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: ○ 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
Facility	25%	Coinsurance
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)[7]	25%	Coinsurance
Radiology Services (e.g., X-Rays)	$30	Copayment
Laboratory Tests	$10	Copayment
Cancer Chemotherapy and Other Provider Administered Drugs[8]	10%	Coinsurance

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

[#] Includes telehealth services.

[8] Cost Sharing applies to professional/administration fees, and the associated drug.

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	$600	Copayment per day; maximum two Copayments per admission
Professional Physician/Surgeon Fee	$10	Copayment
Rehabilitation Services (Limited to 60 days per calendar year)	$10	Copayment
Skilled Nursing Facility[9] (Limited to 90 days per calendar year)	$600	Copayment per day
Hospice Care[10]	No Charge	

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

[10] Includes out-of-network coverage.

Prescription Drug Coverage[11, 12]	At Participating Providers, You Pay	
Tier-1: Preferred Generic Drugs	$0	Copayment
Tier-2: Preferred Brand Drugs	$10	Copayment
Tier-3: Non-Preferred Brand and Generic Drugs	10%	Coinsurance
Tier-4: Brand and Generic Specialty Drugs	10%	Coinsurance
Tier-5: Preventive Drugs[13]	No Charge	
Mail-Order Prescription Drugs	Up to a 90-day supply is offered at two-and-a-half times the 30-day prescription Cost Sharing.	

[11] For details, please refer to the Agreement section titled "Prescription Drugs."
[12] Cost-sharing for insulin is capped at $30 per thirty day supply of each prescription insulin drug.
[13] Includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	25%	Coinsurance
Hearing Aids (Limited to one hearing aid per Member per ear every 36 months)	25%	Coinsurance
Home Health Care[14] (Limit of 100 visits per year for all home health care visits, except private duty nursing visits. One visit equals at least 4 hours.) (Limit of 250 visits per year for private duty nursing visits in the home. One visit equals 8 hours.)	No Charge	
Dialysis Services	$10	Copayment

[14] 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 (Ground Ambulance[15]) (Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers)	25%	Coinsurance
Emergency Medical Transportation (Air Ambulance) (Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers)	25%	Coinsurance

[15] 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.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge, in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019; TTY (800) 537-7697.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه! اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان در اختیار شما است. با خدمات اعضاء تماس بگیرید. شماره تلفن مربوطه در پشت کارت عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ. ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)