

Passport by Molina Healthcare
SCHEDULE OF BENEFITS
Marketplace – Silver 1 100 + Vision

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
Combined Medical & Pharmacy Deductible	
Individual	\$0
Entire Family of 2 or more Members	\$0
Annual Out-of-Pocket Maximum ¹	At Participating Providers, You Pay
Individual	\$1,650
Entire Family of 2 or more	\$3,300

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}	20%	Coinsurance
Urgent Care Services (Services must be provided by a Participating Provider facility.)	\$5	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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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[#] <ul style="list-style-type: none"> Including Autism Spectrum Disorder 	\$0	Copayment per visit
Substance Abuse Disorder Services[#]	\$0	Copayment per visit
Dental Services Related to Accidental Injury	20%	Coinsurance
Treatment for Temporomandibular Joint Disorders (Medically Necessary surgical and arthroscopic treatment)	20%	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 <i>Frames</i> <ul style="list-style-type: none"> Limited to 1 pair of frames every calendar year Limited to a selection of covered frames <i>Lenses</i> <ul style="list-style-type: none"> 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) <p>Includes one pair of replacement eyeglasses every 12 months or repair of lenses and/or frames when Medically Necessary.</p>	No Charge
Prescription Contact Lenses <ul style="list-style-type: none"> In lieu of prescription glasses, prescription contact lenses covered with a minimum 3-month supply for any of the following modalities every calendar year: <ul style="list-style-type: none"> 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

Adult Routine Vision Services (for Members age 21 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 <i>Frames</i>	No Charge

<ul style="list-style-type: none"> Limited to 1 pair of frames every calendar year (up to a \$150 allowance) Lenses <ul style="list-style-type: none"> Limited to 1 pair every calendar year Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses 	
Prescription Contact Lenses <ul style="list-style-type: none"> 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

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgical and Non-Surgical Services[#] – including Outpatient Intensive Psychiatric Treatment Programs		
Professional	20%	Coinsurance
Facility	20%	Coinsurance
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI) ⁷	20%	Coinsurance
Radiology Services (e.g., X-Rays)	\$30	Copayment
Laboratory Tests	\$10	Copayment
Cancer Chemotherapy and Other Provider Administered Drugs⁸	20%	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) <ul style="list-style-type: none"> Medical/Surgical Maternity Care Mental/Behavioral Health Services Substance Use Disorder 	20%	Coinsurance
Professional Physician/Surgeon Fee	20%	Coinsurance
Rehabilitation Services (Limited to 60 days per calendar year)	20%	Coinsurance
Skilled Nursing Facility⁹ (Limited to 90 days per calendar year)	20%	Coinsurance
Hospice Care¹⁰	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	
Preferred Generic Drugs	\$0	Copayment
Preferred Brand Drugs	\$30	Copayment
Non-Preferred Brand and Generic Drugs	20%	Coinsurance
Brand and Generic Specialty Drugs	20%	Coinsurance
Preventive Drugs¹³	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	20%	Coinsurance
Hearing Aids (Limited to one hearing aid per Member per ear every 36 months)	20%	Coinsurance
Home Health Care¹⁴ (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)	20%	Coinsurance
Emergency Medical Transportation (Air Ambulance) (Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers)	20%	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.