SCHEDULE OF BENEFITS

Passport by Molina Healthcare
Passport Silver Core LCS Plus with Adult Dental and 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.

Benefit	At Participating Providers, You Pay
Annual Medical Deductible per Calendar Year	$6,000 / $12,000 (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.	$8,990 / $17,980 (Individual/Family)

Outpatient Professional Services	At Participating Providers, You Pay
Primary Care Provider (PCP) and Other Practitioner Care Office Visit	$35 Copayment per visit
Specialist Office Visit	$60 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)	$35 Copayment per visit
Substance Use Disorder Services	$35 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.	$35 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	$35 Copayment per visit
Notes: • 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	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible

Outpatient Hospital / Facility Services	At Participating Providers, You Pay
Laboratory Tests	$85 Copayment
Radiology Services (e.g., X-Rays)	$95 Copayment
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.*	40% Coinsurance after Deductible
Dental Services Related to Accidental Injury	40% Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs	50% 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	$75 Copayment after Deductible
Non-Preferred Brand and Generic Drugs	50% Coinsurance after Deductible
Brand and Generic 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.

Notes:

- Cost-sharing for insulin is capped at $30 per 30-day supply of each prescription insulin drug.
- Preventive Drugs includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription.

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.	40% Coinsurance after Deductible	40% 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.	40% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Services (must be provided by a Participating Provider)	$60 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	40% Coinsurance after Deductible
Professional Physician/Surgeon Fee	40% Coinsurance after Deductible
Rehabilitation Services • Limited to 60 days per calendar year	40% Coinsurance after Deductible
Skilled Nursing Facility • Limited to 90 days per calendar year • Services must be billed by a Skilled Nursing Facility Participating Provider	40% Coinsurance after Deductible
Hospice Care (includes out-of-network coverage)	No charge
Other Covered Services	**At Participating Providers, You Pay**
Durable Medical Equipment	40% Coinsurance after Deductible
Hearing Aids • Limited to one hearing aid per Member per ear every 36 months	40% Coinsurance after Deductible
Home Health Care (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)). • 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.	40% Coinsurance after Deductible
Dialysis Services	$60 Copayment
Treatment for Temporomandibular Joint Disorders (Medically Necessary surgical and arthroscopic treatment)	40% Coinsurance after Deductible
Family Planning	No charge

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: 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 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 *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
Adult Dental Services (for Members age 21 and older)	**At Participating Providers, You Pay**
All dental services are subjected to an annual maximum of $1,000 per Plan year. No services are subject to a Deductible.	
Diagnostic & Preventive (Limited to 1 every 6 months)	No charge
Basic Dental Services	50% Coinsurance
Major Dental Services (Available after 6 consecutive months of enrollment)	50% Coinsurance
Orthodontics Medically necessary orthodontics and accidental dental are covered under Medical benefits.	Not Covered
Waiting Periods are calculated for each Adult Enrollee from the effective date of coverage reported by the Exchange for said Adult Enrollee. Prior coverage for Adult Enrollees under any Delta Dental Exchange plan that included an adult Waiting Period will be credited towards the adult Waiting Period under this dental plan. In order for prior coverage to be credited, such prior coverage must occur immediately preceding the election of this plan.	