MOLINA HEALTHCARE OF MICHIGAN, INC.
SCHEDULE OF BENEFITS
Marketplace – Constant Care Silver 1 150 + Vision

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF MICHIGAN, INC. AGREEMENT AND INDIVIDUAL CERTIFICATE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

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, Urgent Care Services, and for exceptions described in the section of the Agreement titled "No Participating Provider to Provide a Covered Service"

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$750
Entire Family of 2 or more Members	$1,500
Prescription Drug Deductible	
Individual	$750
Entire Family of 2 or more Members	$1,500
Annual Maximum Out-of-Pocket[1]	**At Participating Providers, You Pay**
Individual	$3,000
Entire Family of 2 or more Members	$6,000
[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to the Annual Maximum Out-of-Pocket.	

Emergency and Urgent Care Services	**You Pay**	
Emergency Services[2] Cost Sharing waived if admitted directly to the hospital for inpatient services. Inpatient Cost Sharing applies if admitted. Refer to "Inpatient Hospital Services" below for applicable Cost Sharing information.)	$600	Copayment per visit
Urgent Care Services Services must be provided by a Participating Provider	$6	Copayment per visit
[2] Please note: Members may be responsible for provider charges that exceed the allowed amount covered under this benefit for emergency/urgent care services rendered by a Non-Participating Provider. Please refer to the section of the Agreement titled "Emergency Services" for more information		

Outpatient Professional Services[3]	At Participating Providers, You Pay	
Office Visits[4]		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care (PCP) and Other Practitioner Care	$6	Copayment per visit
Specialty Care	$30	Copayment per visit
Habilitative Services • Physical and Occupational Therapy (Combined benefit limit of 30 visits per calendar year; Includes osteopathic and chiropractic manipulation) • Speech Therapy (Limit of 30 visits per calendar year)	$30	Copayment per visit
Rehabilitative Services • Physical and Occupational Therapy (Combined benefit limit of 30 visits per calendar year; Includes osteopathic and chiropractic manipulation) • Speech Therapy (Limit of 30 visits per calendar year) • Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined benefit limit of 30 visits per calendar year) • Breast Cancer Rehabilitation	$30	Copayment per visit
Mental/Behavioral Health Services	$6	Copayment per visit
Substance Use Disorder Services	$6	Copayment per visit
Autism Spectrum Disorder Services	$6	Copayment per visit
Family Planning	No Charge	
Treatment of Underlying Cause of Infertility	$30	Copayment per visit

[3]Please 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.
[4] 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.

Vision Services	At Participating Providers, You Pay
Pediatric Vision Services (for Members under the age of 19 only)	
Vision Exam (Screening and exam, limited to 1 each calendar year)	No Charge
Prescription Glasses Frames: • Limited to one pair of frames every 12 months • Limited to a selection of covered frames	No Charge

Lenses (Limited to one pair of prescription lenses every 12 months): • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • Scratch resistant coating, UV protection	
Prescription Contact Lenses In lieu of prescription glasses, limited to 1 pair of standard contact lenses every calendar year. 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) 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

Outpatient Services	**At Participating Providers, You Pay**	
Outpatient Surgical and Non-Surgical Services • Including Outpatient Intensive Psychiatric Treatment Programs		
Professional	30%	Coinsurance after medical deductible
Facility	30%	Coinsurance after medical deductible
Specialized Scanning Services/Imaging[5] (e.g.,CT/PET Scans, MRIs)	30%	Coinsurance after medical deductible

Radiology Services (e.g. X-Rays)	$75	Copayment
Laboratory Services	$30	Copayment
[5]Unless these services are performed while the Member is in an inpatient setting, Cost Share amount for these services will apply		

Inpatient Hospital Services	**At Participating Providers, You Pay**	
Medical/Surgical		
Professional Physician/Surgeon Fee	$30	Copayment
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)	$750/day	Copayment (2 Copay maximum per visit)
Skilled Nursing Facility (Limited to 45 days per calendar year; Services must be billed by a Skilled Nursing Facility Participating Provider)	$750/day	Copayment
Hospice Care (Coverage includes inpatient and outpatient hospice care. Limited to 45 days per calendar year for facility-based care)	No Charge	

Prescription Drugs[6]	**At Participating Providers, You Pay**	
Tier-1 : Preferred Generic Drugs	$5	Copayment
Tier-2 : Preferred Brand Drugs	$25	Copayment
Tier-3: Non-Preferred Brand and Generic Drugs	30%	Coinsurance after Rx drug deductible
Tier-4: Brand and Generic Specialty Drugs	30%	Coinsurance after Rx drug deductible
Tier-5 Preventive Drugs	No Charge	
Mail-Order Prescription Drugs (Applies only to Drug Tiers 1, 2, 3 & 5)	Up to a 90-day supply is offered at two-and-a-half times the 30- day prescription Cost Sharing.	
[6]For details, please refer to the Agreement section titled "Prescription Drug" Please note: 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.		

Ancillary Services	**At Participating Providers, You Pay**	
Durable Medical Equipment	30%	Coinsurance after medical deductible
Home Healthcare	No Charge	

(Services must be billed by a Home Healthcare Participating Provider agency)	(Separate cost share may apply for other covered benefits delivered in the home setting)	
Emergency Medical Transportation • Ambulance (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	30%	Coinsurance after medical deductible
Dialysis Services (Applies to facility charges only. This is outpatient cost sharing. For inpatient dialysis, inpatient hospital cost sharing applies.)	$30	Copayment
Eye Care Treatment (Limited to medical treatment for medical conditions and diseases of the eye)	$30	Copayment
Diabetes Education	No Charge	
Dietitian Services (Limited to 6 visits per calendar year)	No Charge	
Weight Loss Services	No Charge	

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)