MOLINA HEALTHCARE OF MICHIGAN, INC.

SCHEDULE OF BENEFITS

Marketplace – Gold 1 with Adult Vision Services

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF MICHIGAN, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE 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. Molina will pay an "Allowed Amount" (sometimes referred to as "Recognized Amount"), which is the maximum amount that Molina 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 amount (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was a Participating Provider. Molina will pay Non-Participating Providers and Facilities directly for these Covered Services. See your Agreement for more details.

Deductible Type	At Participating Providers, You Pay
Combined Medical & Pharmacy Deductible	
Individual	$1,550
Entire Family of 2 or more Members	$3,100
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$8,100
Entire Family of 2 or more	$16,200

[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]	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.

[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	$20	Copayment per visit
Specialty Care	$50	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)	$20	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	$20	Copayment per visit
Mental/Behavioral Health Services[#] • Including Autism Spectrum Disorder	$20	Copayment per visit
Substance Abuse Disorder Services[#]	$20	Copayment per visit
Dental Services Related to Accidental Injury	25%	Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders • Medically Necessary surgical and arthroscopic treatment	25%	Coinsurance after Deductible
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 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) 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

Adult Routine Vision Services (for Members age 19 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) • Limited to a selection of covered frames *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	No Charge

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.	

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	25%	Coinsurance after Deductible
Specialized Scanning Services e.g., CT Scan, PET Scan, MRI[7]	25%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	25%	Coinsurance after Deductible
Laboratory Tests	$15	Copayment
Cancer Chemotherapy and Other Provider Administered Drugs[8]	30%	Coinsurance after Deductible

[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 (Inpatient Psychiatric Hospitalization) • Substance Use Disorder (Transitional Residential Recovery and Services Inpatient Detoxification)	25%	Coinsurance after Deductible
Professional Physician/Surgeon Fee	25%	Coinsurance after Deductible
Skilled Nursing Facility[9] • Limited to 45 days per calendar year	25%	Coinsurance after Deductible
Hospice Care • Coverage includes inpatient and outpatient hospice care • Limited to 45 days per calendar year for facility-based care	No Charge	

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

Prescription Drug Coverage[10]	At Participating Providers, You Pay	
Preventive Drugs[11]	No Charge	
Preferred Generic Drugs	$15	Copayment

Preferred Brand Drugs	$50	Copayment after Deductible
Non-Preferred Drugs	30%	Coinsurance after Deductible
Specialty Drugs	30%	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.	

[10] For details, please refer to the Agreement section titled "Prescription Drugs."
[11] Includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment • Limited to one item per Member per every 36 months	25%	Coinsurance after Deductible
Home Health Care[12]	No Charge	
Dialysis Services • Applies to facility charges only • This is outpatient cost sharing. For inpatient dialysis, inpatient hospital cost sharing applies.	$50	Copayment
Eye Care Treatment • Limited to medical treatment for medical conditions and diseases of the eye	$50	Copayment
Diabetes Education	No Charge	
Dietitian Services	No Charge	

[12] 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[13] • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers	25%	Coinsurance after Deductible
Emergency Medical Transportation Air Ambulance • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers	25%	Coinsurance after Deductible

[13] 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.