MOLINA HEALTHCARE OF MISSISSIPPI, INC.
SCHEDULE OF BENEFITS
Marketplace – Bronze 8

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

NOTICE: THIS PRODUCT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE IN THE MARKETPLACE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR THE FEDERALLY FACILITATED MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STAND-ALONE DENTAL SERVICES PRODUCT.

In general, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider for Emergency Services and for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$7,500
Entire Family of 2 of more Members	$15,000
Prescription Drug Deductible	
Individual	Included in Medical Deductible
Entire Family of 2 or more Members	Included in Medical Deductible
Annual Out-of-Pocket Maximum (OOPM) [1]	**At Participating Providers, You Pay**
Individual	$9,400
Entire Family of 2 or more Members	$18,800

[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your annual OOPM.

Emergency and Urgent Care Services [2]	**You Pay**	
Emergency Services [3]	50%	Coinsurance after Deductible
Urgent Care Services – Services must be provided by a Participating Provider	$75	Copayment per visit

[2] Please note: Please note: Except as otherwise provided by state law, You will be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Emergency Services rendered by a Non-Participating Provider. Please refer to the section 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.

Outpatient Professional Services [4]	At Participating Providers, You Pay	
Office Visits [5]		
Preventive Care (Includes prenatal and postpartum exams)	No Charge	
Primary Care (PCP) and Other Practitioner Care	$50	Copayment per visit
Specialty Care	$100	Copayment per visit
Habilitative Services	$50	Copayment per visit
Rehabilitative Services • 20 combined outpatient physical therapy, occupational therapy and chiropractic care visits per calendar year. • 20 speech therapy visits per calendar year. • 36 cardiac rehab visits per calendar year.	$50	Copayment per visit
Chiropractic Services • 20 combined outpatient physical therapy, occupational therapy and chiropractic care visits per calendar year.	$50	Copayment per visit
Mental Health or Substance Abuse Services (including office visits)	$50	Copayment per visit
Dental Services Related to Accidental Injury	50%	Coinsurance after Deductible
Family Planning	No Charge	

[4] 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.

[5] 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, 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.

Pediatric Vision Services (for Members under age 19 only)	
Comprehensive Vision Exam • Exam limited to one each calendar year.	No Charge
Prescription Glasses	
Frames • Limited to one pair of frames every calendar year • Limited to a selection of covered frames Lenses • Limited to one pair of frames every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses All lenses include scratch resistant coating, and ultraviolet protection (UV)	No Charge

Prescription Contact Lenses • (In lieu of prescription glasses, prescription contact lenses covered with a minimum three-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 and Prior Authorization applies		No Charge
Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Outpatient Surgical and Non-Surgical Services		
Professional	50%	Coinsurance after Deductible
Facility	50%	Coinsurance after Deductible
Specialized Scanning Services [6] (e.g., CT Scan, PET Scan, MRI)	50%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	50%	Coinsurance after Deductible
Laboratory Tests	50%	Coinsurance after Deductible
Mental/Behavioral Health/Substance Abuse • Outpatient Intensive Psychiatric Treatment Programs	50%	Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs. **Note:** Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	50%	Coinsurance after Deductible
Inpatient Hospital Services	**At Participating Providers, You Pay**	
Medical / Surgical		
Professional Physician/Surgeon Fee • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Abuse Disorder • Rehabilitative Services	50%	Coinsurance after Deductible
Facility Fee (e.g., hospital room) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder • Rehabilitative Services	50%	Coinsurance after Deductible
Cancer Chemotherapy and Other Provider Administered Drugs. **Note:** Please refer to the Outpatient Hospital/Facility Services or the Inpatient Hospital Services sections of this document for more details.	50%	Coinsurance after Deductible
Skilled Nursing Facility	50%	Coinsurance after Deductible

• Limited to 30 days per calendar year Services must be billed by a Skilled Nursing Facility Participating Provider		
Hospice Care	No Charge	

[6] Unless these services are performed while You are in an inpatient setting, Your Cost Share amount for these services will apply.

Prescription Drug Coverage [7]	**At Participating Providers, You Pay**	
Preferred Generic Drugs	$25	Copayment
Preferred Brand Drugs	$50	Copayment after Deductible
Non-Preferred Brand and Generic Drugs	$100	Copayment after Deductible
Brand and Generic Specialty Drugs	$500	Copayment after Deductible
Formulary Preventive Drugs	No Charge	
Mail-Order Prescription Drugs (Does not apply to Specialty Drugs.)	Up to a 90-day supply is offered at two-and-a-half times the 30-day prescription Cost Sharing.	

[7] For details, please refer to the EOC section titled "Prescription Drug Coverage."

Please note, Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by You 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 Your EOC.

Ancillary Services	**At Participating Providers, You Pay**	
Durable Medical Equipment	50%	Coinsurance after Deductible
Home Infusion • Administration Only	No Charge	
Home Healthcare • Services must be billed by a Home Healthcare Participating Provider agency • Separate Cost-Sharing may apply for other covered benefits delivered in the home setting, e.g. injectable drugs, durable medical equipment, etc.	No Charge	
Emergency Medical Transportation (Ambulance) • Medically Necessary Emergency Services are covered.	50%	Coinsurance after Deductible

Other Services	**At Participating Providers, You Pay**	
Dialysis Services • applies to facility charges only • This is outpatient cost sharing. For inpatient dialysis, IP hospital cost sharing applies.	$100	Copayment per visit