Molina Healthcare of Ohio, Inc.

SCHEDULE OF BENEFITS

Marketplace – Constant Care Silver 1 250

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE PASSPORT HEALTH PLAN 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, 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 and for exceptions described in the section of the Agreement titled "No Participating Provider to Provide a Covered Service."

Deductible Type	At Participating Providers, Members Pay
Medical Deductible	
Individual	$2,500
Entire Family of 2 or more Members	$5,000
Prescription Drug Deductible	
Individual	$2,500
Entire Family of 2 or more Members	$5,000
Annual Maximum Out-of-Pocket[1]	**At Participating Providers, Members Pay**
Individual	$9,100
Entire Family of 2 or more Members	$18,200
[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to your Annual Out-of-Pocket Maximum.	

Emergency and Urgent Care Services[2]	Members Pay	
Emergency Services[3]	$950	Copayment per visit
Urgent Care Services (Services must be provided by a Participating Provider)	$30	Copayment
[3] Please refer to the sections of the Agreement titled "Emergency Services" and "Urgent Care Services" for more information. [4] This cost does not apply if admitted directly to the hospital for inpatient services. Refer to "Inpatient Services" below for applicable Cost Sharing information.		

Outpatient Professional Services[4]	At Participating Providers, Members Pay	
Office Visits[5]		
Preventive Care (Includes prenatal and first postpartum exam)	No charge	
Primary Care (PCP) and Other Practitioner Care	$30	Copayment
Specialist Care	$60	Copayment
Habilitative Services	$60	Copayment
Rehabilitative Services • Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Therapy – limit of 20 visits per therapy per calendar year • Cardiac Rehabilitation – limit of 36 visits per calendar year • Manipulation Therapy – limit of 12 visits per calendar year	$60	Copayment
Mental Health Services (including office visits)	$30	Copayment
Substance Abuse Services (including office visits)	$30	Copayment
Dental Services Related to Accidental Injury (limited to $3000 per episode)	50%	Coinsurance after Deductible
Vision Services Related to Accidental Injury or Diseases Affecting the Eye	$60	Copayment
Family Planning	No Charge	

[4] 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.

[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, 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, Members Pay
Pediatric Vision Services (Refer to Vision Services section in the Agreement for age limit**)**	
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 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, and	No Charge

other options are listed in the Agreement section titled "Vision Services."	
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

Outpatient Services	At Participating Providers, Members Pay	
Medical Outpatient Professional & Facility • Outpatient Surgery • Outpatient Non-Surgical Services • Sleep Studies (all places of service) Mental / Behavioral Health / Substance Abuse • Outpatient Intensive Psychiatric Treatment Programs Infertility Services • Exploratory procedures to correct diagnosed disease or condition of the reproductive organs		
Professional	50%	Coinsurance after Deductible
Facility	50%	Coinsurance after Deductible
Specialized Scanning Services/Imaging[6] (e.g., CT Scan, PET Scan, MRIs)	50%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	$95	Copayment
Laboratory Tests	$60	Copayment
(Laboratory tests to screen for and determine onset of diabetes, including gestational diabetes)	No Charge	
Cancer Chemotherapy and Other Provider Administered Drugs[7]	50%	Coinsurance

6 Unless these services are performed while the Member is in an inpatient setting, the indicated Cost Share amount for these services will apply

7 Cost Sharing applies to professional/administration fees, and the associated drug.

Inpatient Services	At Participating Providers, Members Pay	
All Inpatient Hospital Services • Medical/Surgical • Maternity Care • Infertility Services (exploratory procedures to correct diagnosed disease or condition of the reproductive organs) • Mental/Behavioral Health Services (Inpatient Psychiatric Hospitalization) • Substance Use Disorder Services (Inpatient Detoxification; Transitional Residential Recovery Services) • Rehabilitative Services (Limit 60 days per calendar year)		
Professional	$60	Copayment

Facility	$1,200	Copayment per day, max 2 copayments per inpatient admission
Skilled Nursing Facility[8] (90 day limit per calendar year)	$1,200	Copayment per day
[8] Services must be billed by a Skilled Nursing Facility Participating Provider.		

Prescription Drugs[9]	**At Participating Providers, Members Pay**	
Tier-1: Preferred Generic Drugs	$29	Copayment
Tier-2: Preferred Brand Drugs	$60	Copayment
Tier-3: Non-Preferred Brand and Generic Drugs	50%	Coinsurance after prescription drug Deductible
Tier-4: Brand and Generic Specialty Drugs (Maximum Cost Sharing of $100 per prescription fill for oral chemotherapy drugs)	50%	Coinsurance after prescription 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.	
[9] 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, Members Pay**	
Durable Medical Equipment (All equipment and supplies other than for diabetes care)	50%	Coinsurance after Deductible
Home Infusion (Administration Only)	No Charge	
Home Healthcare (Limit of 100 visits per year for all home health care visits, except private duty nursing visits) (Limit of 90 visits per year for private duty nursing visits in the home)	No Charge (Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.))	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	50%	Coinsurance after Deductible
Hospice Care	No Charge	

Dialysis Services (applies to Facility charges only. This is outpatient Cost Sharing. For inpatient dialysis, Inpatient hospital Cost Sharing applies.)	$60	Copayment
Diabetes Health Education Services	No Charge	
Transplant Services ($30,000 limit on unrelated donor searches for bone marrow/stem cell transplants per transplant benefit period; $10,000 limit on travel expenses per transplant benefit period.)	$60	Copayment

Balance Billing: Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17, and the Federal No Surprises Act establish patient protections including from Non-Participating Providers' Balance Billing (sometimes called "surprise billing") for Emergency Services and other specified items or services. Molina will comply with these new state and federal requirements including how we process claims from certain Non-Participating Providers.

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.

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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)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេងៗគ្នាដូចជាអូឌីយ៉ូប្រ៊ែលឬពុម្ពអក្សរធំដោយសារតែតម្រូវការពិសេសឬភាសារបស់អ្នកដោយមិនគិតថ្លៃបន្ថែម។ (Cambodian)