SCHEDULE OF BENEFITS

Molina Healthcare of Ohio, Inc.
Molina Silver Core LCS

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, 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 Out-of-Pocket Maximum. 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."

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.

	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 (including Allergy Testing)	$35 Copayment per visit
Specialist Office Visit	$60 Copayment per visit (Member cost-sharing may vary based on the types of services received and the place of service where it is rendered. Members should check with their provider before receiving services.)
Virtual Care provided by Teladoc Health	No charge
Preventive Care (including screenings, immunizations and well-baby visits)	No charge
Mental/Behavioral Health Services Office Visit	$35 Copayment per visit (Member cost-sharing may vary based on the types of services received and the place of service where it is rendered. Members should check with their provider before receiving services.)
Substance Use Disorder Services Office Visit	$35 Copayment per visit (Member cost-sharing may vary based on the types of services received and the place of service where it is rendered. Members should check with their provider before receiving services.)
Habilitative Services • Speech Therapy – limit of 20 visits per calendar year • Occupational Therapy – limit of 20 visits per calendar • Clinical Therapeutic Intervention – limit of 20 hours per week	$35 Copayment per visit
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	$35 Copayment per visit
Dental Services Related to Accidental Injury • Limited to $3,000 per episode	40% Coinsurance after Deductible
Vision Services Related to Accidental Injury or Diseases Affecting the Eye	$60 Copayment
Family Planning	No charge

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.
- Cost Sharing for Covered Services provided by a licensed occupational therapist, physical therapist, or chiropractor will be capped at the same amount as an office visit for a "Primary Care (PCP) and Other Practitioner Care."

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)
Radiation Therapy	40% Coinsurance after Deductible
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 (Applies only to Preventive Drugs, Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand and Generic Drugs)	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:

- Maximum Cost Sharing of $100 per prescription fill for oral chemotherapy drugs.

• 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.		
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 • 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)	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	
Other Covered Services	**At Participating Providers, You Pay**	
Diabetes Health Education Services	No charge	
Dialysis Services	$60 Copayment	

Durable Medical Equipment (All equipment and supplies other than for diabetes care)	40% Coinsurance after Deductible
Hearing Aids • Limit 1 hearing aid per ear, every 48 months up to $2,500 for members 21 years old or younger	No charge
Home Infusion (Fee for administration only)	No charge (Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.))
Home Health Care • 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.	40% Coinsurance after Deductible (Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.))
Hospice Care	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.	40% Coinsurance after Deductible
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 of prescription lenses every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • Scratch resistant coating, UV protection, and other options are listed in the Agreement section titled “Vision Services.” 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