MOLINA HEALTHCARE OF SOUTH CAROLINA, INC.
MAJOR MEDICAL EXPENSE COVERAGE HMO
SCHEDULE OF BENEFITS

Marketplace – Silver 1 100

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

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. 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."

Deductible	At Participating Providers, You Pay
Individual	$0
Entire Family of 2 or more Members	$0
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$1,650
Entire Family of 2 or more	$3,300

[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]	20%	Coinsurance
Urgent Care Services (Services must be provided by a Participating Provider facility.)	$5	Copayment per visit

[2] 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 first postpartum exam)	No Charge	
Primary Care (PCP) and Other Practitioner Care	No Charge	
Specialty Care	$10	Copayment per visit
Habilitative Services	$10	Copayment per visit
Rehabilitative Services[6]	$10	Copayment per visit
Mental Health or Substance Use Disorder Services	No Charge	
Dental Services Related to Accidental Injury	20%	Coinsurance
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 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.

[6] Physical therapy, speech therapy, and occupational therapy are limited to 30 visits per therapy type per year.

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)	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

Outpatient Hospital / Facility Services	At Participating Providers, You Pay

Outpatient Surgical and Non-Surgical Services – including Outpatient Intensive Psychiatric Treatment Programs		
Professional	20%	Coinsurance
Facility	20%	Coinsurance
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)[7]	20%	Coinsurance
Radiology Services (e.g., X-Rays)	$30	Copayment
Laboratory Tests	$10	Copayment

[7] Unless Specialized Scanning Services are performed while you are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.

Inpatient Hospital Services	At Participating Providers, You Pay	
Facility Fee (e.g., hospital room) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder	20%	Coinsurance
Professional Physician/Surgeon Fee	20%	Coinsurance
Skilled Nursing Facility[8] (Limited to 60 days per calendar year)	20%	Coinsurance
Hospice Care	No Charge	

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

Prescription Drug Coverage[9]	At Participating Providers, You Pay	
Preferred Generic Drugs	No Charge	
Preferred Brand Drugs	$30	Copayment
Non-Preferred Drugs	20%	Coinsurance
Specialty Drugs	20%	Coinsurance
Preventive Drugs	No Charge	
Mail-Order Prescription Drugs	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 Drugs." 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 Plan.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	20%	Coinsurance
Home Health Care[10] (Limited to 60 visits per calendar year)	No Charge	

[10] 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	
Ground Ambulance (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers. Members may be responsible for Balance Billing for provider charges that exceed the Allowed Amount covered under this benefit for Ground Ambulance services rendered by a Non-Participating Provider.)	20%	Coinsurance, plus amounts that exceed the Allowed Amount
Air Ambulance (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	20%	Coinsurance

Other Services	At Participating Providers, You Pay	
Dialysis Services	$10	Copayment per visit