

MOLINA HEALTHCARE OF TEXAS, INC.
SCHEDULE OF BENEFITS
2023 Constant Care Silver 1 100 + Vision

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

NOTICE: THIS PRODUCT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. COVERAGE FOR PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE ON A STANDALONE BASIS THROUGH THE HEALTH INSURANCE MARKEPLACE. PLEASE CONTACT THE HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL SERVICES.

Except for Emergency Services and Medically Necessary Prior Authorization, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to the Deductible and Out-of-Pocket Maximum. Please see How Do I Get Medical Services Through Molina Healthcare for more information.

Deductible Type	At Participating Providers, You Pay
Medical Deductible Deductible waived for preventive care services	
Individual	\$0
Entire Family of 2 or more Members	\$0
Other Deductibles	
Prescription Drug Deductible (Applies only to Tier 3 -Non-Preferred Brand and Tier 4 -Specialty Drugs) (Deductible waived for Preventative Drugs)	
Individual	\$0
Entire Family of 2 or more Members	\$0
Annual Out of Pocket Maximum ¹	At Participating Providers, You Pay
Individual	\$1,400
Entire Family of 2 or more Members	\$2,800

¹Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your Annual Out of Pocket Maximum.

Emergency Room and Urgent Care Services	You Pay	
Emergency Room ² - Applies to facility charges only. Additional Copayments will not be charged for additional Emergency Room services such as professional fees.	\$350	Copayment per visit
Urgent Care – Applies to facility charges only. Additional Copayments will not be charged for additional Urgent Care services such as professional fees. Services must be provided by a Participating Provider Urgent Care center.	\$0	Copayment per visit

²This cost does not apply, if admitted directly to the hospital for inpatient services. Refer to “Inpatient Hospital Services”, for Your applicable Cost Sharing.

Outpatient Professional Services ³	At Participating Providers, You Pay	
Office Visits ⁴		
Preventive Care Services (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	\$0	Copayment per visit
Specialty Care	\$10	Copayment per visit
Other Practitioner Care	\$0	Copayment per visit
Telehealth	No Charge	
Habilitative Services — 35 visits per plan year, does not apply to Mental / Behavioral Health Services and Substance Abuse Disorder Services conditions.	\$10	Copayment per visit
Rehabilitative Services — 35 visits per plan year, including covered chiropractor services. The chiropractor must provide services in connection with outpatient rehabilitation, speech therapy, occupational therapy and physical therapy.	\$10	Copayment per visit
Mental/Behavioral Health Services	\$0	Copayment per visit

Outpatient Professional Services ³		At Participating Providers, You Pay	
Substance Abuse/Chemical Dependency Services		\$0	Copayment per visit
Pediatric Vision Services (for Members under age 19 only)			
Vision Exam <ul style="list-style-type: none"> (Screening and exam, limited to 1 exam each plan year) 		No Charge	
Prescription Glasses			
Frames <ul style="list-style-type: none"> Limited to 1 pair of frames every 12 months Limited to a selection of covered frames 		No Charge	
Lenses <ul style="list-style-type: none"> Limited to 1 pair of prescription lenses every 12 months Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses, Fashion and gradient tinting, oversized and grey glasses #3 prescription sunglass lenses, All lenses include scratch resistant coating, UV protection, 		No Charge	
Prescription Contact Lenses In lieu of prescription glasses, one pair of prescription contact lenses once every 12 months. Medically Necessary contact lenses for specified medical conditions require prior authorization.		No Charge	
Adult Routine Vision Services (for Members age 19 and older)			
Comprehensive Vision Exam (limited to 1 each calendar year)		No Charge	
Routine Retinal Screening		\$39 Copayment	
Prescription Glasses			
Frames	<ul style="list-style-type: none"> Limited to one pair of frames every calendar year Limited to a selection of covered frames 	No Charge	
Lenses	<ul style="list-style-type: none"> Limited to one pair every calendar year Glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses 	No Charge	
Prescription Contact Lenses		No Charge	
(In lieu of prescription glasses, materials and services 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 Professional Services**	At Participating Providers, You Pay	
Hearing Aids (limit 1 hearing aid every 36 months) Please refer to the Hearing Services section of this EOC for full details.	\$600	Copayment per hearing aid
Family Planning	No Charge	

³ Please note, if you are seen in a hospital-based clinic, outpatient hospital cost-sharing 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.

⁴ For services, such as laboratory and x-ray that are provided on the same date of service as an office visit to a PCP or a Specialist, 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 at a separate location, even if on the same day as an office visit.

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgical and Non-Surgical Services		
Professional	25%	Copayment per visit
Health Care Facility (e.g., Ambulatory Surgical Center) Note: includes internally implanted devices	25%	Copayment per visit
Endoscopic Procedures (Medically Necessary exams, tests, and procedures). Endoscopic procedures covered as preventive care services in accordance with the provisions of this EOC are not subject to the Medically Necessary requirement, and such procedures will be at no charge.	25%	Copayment per visit
Sleep Studies	25%	Copayment per visit
Administration of Injections and Infusion Therapy	25%	Copayment per instance

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Specialized Scanning Services (CT Scan, PET Scan, MRI) ⁵	25%	Copayment per test
Radiology Services (X-ray)*	\$30	Copayment per test
Chemotherapy	10%	Copayment per test
Laboratory Tests*	\$10	Copayment per test
Mental/Behavioral Health Services		
Outpatient Intensive Psychiatric Treatment Programs	25%	Copayment per day

⁵Unless these services are performed while You are in an inpatient setting, Your Cost Share amount for these services will apply.

*Please Note: 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.

Inpatient Hospital Services	At Participating Providers, You Pay	
Medical / Surgical		
Professional	\$10	Copayment per day
Health Care Facility Note: Covered services while inpatient confined include: whole blood and blood, including the cost of blood, blood plasma and blood plasma expanders, and administration of whole blood and blood plasma Coverage also includes internally implanted devices.	\$600 max 2 copayment	Copayment per day
Maternity Care (professional services)	\$10	Copayment per day

Inpatient Hospital Services	You Pay	
Maternity Care (facility services)	\$600 max 2 copayment	Copayment per day
Mental/Behavioral Health Services (Inpatient Psychiatric Hospitalization)	\$600 max 2 copayment	Copayment per day
Substance Abuse Disorder Services		
Inpatient Detoxification	\$600 max 2 copayment	Copayment per day
Transitional Residential Recovery Services	\$600 max 2 copayment	Copayment per day
Skilled Nursing Facility (limited to 25 days per plan year) (Services must be billed by a Skilled Nursing Facility Participating Provider)	\$600	Copayment per day
Hospice Care	No Charge	
Prescription Drug Coverage ⁶	At Participating Providers, You Pay	
Tier-1: Preferred Generic Drugs	\$0	Copayment per 30-day supply
Tier-2: Preferred Brand Drugs	\$10	Copayment per prescription
Tier-3: Non-Preferred Brand and Generic Drugs	10% after Deductible	Copayment per prescription
Tier-4: Brand and Generic Specialty Drugs	10% after Deductible	Copayment per prescription
Tier-5: Preventive Drugs	No Charge Deductible does not apply	
Mail-order Prescription Drugs (Applies only to Drug Tiers 1, 2, 3 & 5)	Cost sharing for a 90-day supply by mail order is two-and-a-half times the cost sharing for a standard 30-day supply. Available for tiers 1,2,3, and 5.	

⁶All of Molina’s contracted pharmacies have processes in place to allow You to pick up all of your ongoing prescription refills on a single, convenient day each month. If less than a full refill is provided to You as a result of this process, You will only be charged for the amount of medication You receive. Please refer to “PRESCRIPTION DRUGS” section for a description of prescription drug coverage.

Your cost for covered prescription drugs is never more than the lesser of: Your applicable copayment or coinsurance amount, the allowable claim amount, or the amount You would pay if purchasing without health benefits or discounts.

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

Outpatient and Inpatient Mental/Behavioral health services and Substance abuse/Chemical dependency services for covered services of mental health conditions and substance use disorders is provided on the same terms and conditions as medical or surgical benefit expenses for any other physical illness.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	25%	Copayment per request
Prosthetic and Orthotic Devices Note: includes coverage for medically necessary hearing aids and cochlear implants and related services and supplies such as fitting, dispensing, treatment for habilitation and rehabilitation and, for cochlear implants, an external speech processor and controller with necessary component and replacement every three years.	25%	Copayment per request
Home Health Care (Limited to 60 visits per plan year)(Services must be billed by a Home Healthcare Participating Provider agency) Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.).	No Charge per visit	
Ancillary Services – Emergency Medical Transportation	You Pay	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for Participating and Non-Participating Providers.)	25%	Copayment per trip
Other Services	At Participating Providers, You Pay	
Dialysis Services	\$10	Copayment per service



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.

LANGUAGE ACCESS

If you, or someone you're helping, have questions about Molina Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1 (888) 560-2025.

Árabe	إذا كانت لديك أنت أو أي شخص آخر تساعده أسئلة حول Molina Marketplace فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث إلى مترجم فوري، اتصل على
Chino	如果您，或是您正在協助的對象，有關於Molina Marketplace方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1 (888) 560-2025。
Francés	Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Molina Marketplace, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1 (888) 560-2025.
Alemán	Falls Sie oder jemand, dem Sie helfen, Fragen zum Molina Marketplace haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1 (888) 560- 2025 an.
Gujarati	જો તમને અથવા તમે જેને મદદ કરી રહ્યાં હોવ એવી કોઈ વ્યક્તિને Molina Marketplace વિશે પ્રશ્નો હોય, તો કોઈ ખર્ચે વગર તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, 1 (888) 560 2025 પર કોલ કરો.
Hindi	यदि आपके या आपके द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Molina Marketplace के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी भी दूरभाषिण से बात करने के लिए, 1 (888) 560-2025 पर कॉल करें।
Japonés	ご本人様、またはお客様の身の回りの方でも、Molina Marketplace についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1 (888) 560-2025までお電話ください。
Coreano	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Molina Marketplace 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1 (888) 560-2025로 전화하십시오.
Loasiano	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ Molina Marketplace, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ຕ້ອງເສຍຄ່າບໍລິການ. ຖ້າທ່ານຕ້ອງການເວົ້າກັບ ວ່າມແປພາສາ, ກະລຸນາໂທຫາ 1 (888) 560-2025.
Persian-Farsi	اگر شما یا کسی که به آن کمک می کنید سؤالی درباره Molina Marketplace دارید، می توانید کمک و اطلاعات را به زبان خودتان و به طور رایگان دریافت کنید. برای صحبت با مترجم شفاهی با 1 (888) 560-2025 تماس بگیرید.

Ruso	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Molina Marketplace , то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1(888) 560-2025.
Español	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Molina Marketplace tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1 (888) 560-2025.
Tagalo	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Molina Marketplace, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1 (888) 560-2025.
Urdu	اگر آپ، یا کوئی اور جن کی آپ مدد کر رہے ہیں، ان کے پاس Molina Marketplace کے بارے میں سوالات ہوں، تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق حاصل ہے۔ کسی ترجمان سے بات کرنے کے لیے، 1 (888) 560-2025 پر کال کریں۔
Vietnamita	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Molina Marketplace, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1 (888) 560-2025.