MOLINA HEALTHCARE OF TEXAS, INC.
SCHEDULE OF BENEFITS
2022 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	$1,200
Entire Family of 2 or more Members	$2,400

[1]Medically 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.	$250	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

[2]This cost does au 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 • (Screening and exam, limited to 1 exam • each plan year)	No Charge	
Prescription Glasses		
Frames • Limited to 1 pair of frames every 12 months • Limited to a selection of covered frames	No Charge	
Lenses • 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	

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	$10	Copayment per visit
Health Care Facility (e.g., Ambulatory Surgical Center) Note: includes internally implanted devices	$100	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.	$100	Copayment per visit
Sleep Studies	$100	Copayment per visit
Administration of Injections and Infusion Therapy	$10	Copayment per instance

Outpatient Hospital / Facility Services	**At Participating Providers,** You Pay	
Specialized Scanning Services (CT Scan, PET Scan, MRI) [5]	$50	Copayment per test
Radiology Services (X-ray)*	$15	Copayment per test
Chemotherapy	10%	Copayment per test
Laboratory Tests*	$5	Copayment per test
Mental/Behavioral Health Services		
Outpatient Intensive Psychiatric Treatment Programs	$100	Copayment per day

[5]Unless 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 double the cost sharing for a standard 30-day supply. Available for tiers 1,2,3, and 5.	

[6]All 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	$100	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.	$100	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.)	$100	Copayment per trip
Other Services	**At Participating Providers,** You Pay	
Dialysis Services	$10	Copayment per service