

MOLINA HEALTHCARE OF WISCONSIN, INC.
SCHEDULE OF BENEFITS
Marketplace – Silver 1 100

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF WISCONSIN, INC. 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, 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. Molina will pay an “Allowed Amount” (sometimes referred to as “Recognized Amount”), which is the maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing. 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.” For more details, please see the Agreement.

No Surprises Act Notice: When you get certain Covered Services from Non-Participating Providers (Emergency Services, Post-Stabilization Services, air ambulance services, or Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law), you are protected from Surprise Billing (or Balance Billing). You are only responsible for paying your applicable Cost Sharing amount (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was a Participating Provider. Molina will pay Non-Participating Providers and Facilities directly for these Covered Services. See your Agreement for more details.

Deductible Type	At Participating Providers, You Pay
Combined Medical & Pharmacy Deductible	
Individual	\$0
Entire Family of 2 or more Members	\$0
Annual Out-of-Pocket Maximum¹	
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 Services²	You Pay	
Emergency Services^{3, 4}	20%	Coinsurance
Urgent Care Services <ul style="list-style-type: none"> Services must be provided by a Participating Provider facility 	\$5	Copayment per visit

² Please refer to the sections 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.

⁴ Includes out-of-network coverage.

Outpatient Professional Services⁵	At Participating Providers, You Pay	
Office Visits^{6, #}		
Preventive Care <ul style="list-style-type: none"> Includes prenatal and first postpartum exam 	No Charge	
Primary Care (PCP) and Other Practitioner Care ⁷	\$0	Copayment per visit
Specialty Care	\$10	Copayment per visit
Habilitative Services	\$10	Copayment per visit
Rehabilitative Services <ul style="list-style-type: none"> Limited to 20 visits each per calendar year for Speech, Occupational and Physical Therapy Limited to 20 visits per calendar year for Pulmonary Therapy Limited to 36 visits per calendar year for Cardiac Rehabilitation Therapy 	\$10	Copayment per visit
Manipulation Therapy	\$0	Copayment per visit
Mental/Behavioral Health Services[#] <ul style="list-style-type: none"> Including Autism Spectrum Disorder (Intensive-level services limited to 30 visits per calendar year, Non-intensive level services limited to 20 visits per calendar year). 	\$0	Copayment per visit
Substance Abuse Disorder Services[#]	\$0	Copayment per visit
Dental Services Related to Accidental Injury <ul style="list-style-type: none"> Limited to \$3,000 per year; \$900 per tooth limit 	20%	Coinsurance
Treatment for Temporomandibular Joint Disorders <ul style="list-style-type: none"> Limited to \$1,250 per year 	20%	Coinsurance
Family Planning	No Charge	

⁵ 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.

⁶ 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.

[#] Includes telehealth services.

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 <i>Frames</i> • Limited to 1 pair of frames every calendar year • Limited to a selection of covered frames <i>Lenses</i> • 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) 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	

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 ⁸	20%	Coinsurance
Radiology Services (e.g., X-Rays)	20%	Coinsurance
Laboratory Tests	20%	Coinsurance
Cancer Chemotherapy and Other Provider Administered Drugs⁹ • Intravenous chemotherapy is covered	20%	Coinsurance

⁸ Unless Specialized Scanning Services are performed while you are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.

[#] Includes telehealth services.

⁹ Cost Sharing applies to professional/administration fees, and the associated drug.

Inpatient Hospital Services	At Participating Providers, You Pay	
Facility Fee (e.g., hospital room) <ul style="list-style-type: none"> • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder 	20%	Coinsurance
Professional Physician/Surgeon Fee	20%	Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Combined limit of 60 days/visits per Member per calendar year (Including Speech, Occupational and Physical Therapy) 	20%	Coinsurance
Skilled Nursing Facility ¹⁰ <ul style="list-style-type: none"> • Limited to 30 days per confinement. 	20%	Coinsurance
Hospice Care <ul style="list-style-type: none"> • Limited to 6 months in a 3-year period 	No Charge	

¹⁰ Services must be billed by a Skilled Nursing Facility Participating Provider.

Prescription Drug Coverage ^{11,*}	At Participating Providers, You Pay	
Preventive Drugs ¹²	No Charge	
Preferred Generic Drugs	\$0	Copayment
Preferred Brand Drugs	\$30	Copayment
Non-Preferred Drugs	20%	Coinsurance
Specialty Drugs ¹³	20%	Coinsurance
Mail-Order Prescription Drugs	Up to a 90-day supply is offered at two-and-a-half times the 30-day prescription Cost Sharing.	

¹¹ For details, please refer to the Agreement section titled "Prescription Drugs."

¹² Includes tobacco cessation medications and over-the-counter nicotine replacement with a prescription.

¹³ Maximum cost sharing of \$100 for a 30-day supply of oral chemotherapy drugs

* Cost Sharing for any prescription brand name drugs with a generic equivalent obtained by You through the use of a discount card or coupon card 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 <ul style="list-style-type: none"> • Limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums. • Cochlear implants are included under the Durable Medical Equipment benefit. 	20%	Coinsurance

Hearing Aids <ul style="list-style-type: none"> • Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. • For Enrolled Dependent children under age 18, Benefits are limited to one hearing aid per ear, every three years. 	20%	Coinsurance
Home Health Care¹⁴ <ul style="list-style-type: none"> • Limited to 60 visits per calendar year 	No Charge	
Dialysis Services	\$10	Copayment

¹⁴ 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	
Emergency Medical Transportation Ground Ambulance ¹⁵ <ul style="list-style-type: none"> • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers 	20%	Coinsurance
Emergency Medical Transportation Air Ambulance <ul style="list-style-type: none"> • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers 	20%	Coinsurance

¹⁵ 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.