

MOLINA HEALTHCARE OF ILLINOIS, INC.

SCHEDULE OF BENEFITS

Marketplace – Silver 1 150

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF ILLINOIS, 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.”

No Surprises Act Notice: When you receive 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 the “Access To Care” section of your Agreement for more details.

| Combined Medical and Pharmacy Deductible | At Participating Providers, You Pay |
|--|-------------------------------------|
| Individual | \$850 |
| Entire Family of 2 or more Members | \$1,700 |
| Annual Out of Pocket Maximum ¹ | At Participating Providers, You Pay |
| Individual | \$2,825 |
| Entire Family of 2 or more | \$5,650 |
| 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^{3,4} | 30% | Coinsurance after Deductible |
| Urgent Care Services <ul style="list-style-type: none"> Services must be provided by a Participating Provider facility. | \$25 | 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.

⁴ Includes out-of-network coverage.

| Outpatient Professional Services ⁵ | 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 • Includes allergy testing | \$8 | Copayment per visit |
| Specialty Care • Including consultant and second opinion services | \$30 | Copayment per visit |
| Habilitative Services | \$30 | Copayment per visit |
| Rehabilitative Services • Combined OT/ST/PT limit of 60 visits per year for conditions which are expected to result in significant improvement within 2 months as determined by PCP. • Maintenance therapies are not covered. | \$30 | Copayment per visit |
| Chiropractic and Osteopathic Manipulation • 25 visits per calendar year | \$30 | Copayment per visit |
| Mental/Behavioral Health Services[#] | \$8 | Copayment per visit |
| Substance Abuse Disorder Services[#] | \$8 | Copayment per visit |
| Family Planning | | No Charge |
| <p>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.</p> <p>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.</p> <p>[#] Includes telehealth services.</p> | | |

| 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) | 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 | 30% | Coinsurance after Deductible |
| Facility | 30% | Coinsurance after Deductible |
| Infusion Therapy | 30% | Coinsurance after Deductible |
| Dental Services Related to Accidental Injury | 30% | Coinsurance after Deductible |
| Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI) ⁷ | 30% | Coinsurance after Deductible |
| Radiology Services (e.g., X-Rays) | \$75 | Copayment |
| Laboratory Tests | \$30 | 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) | 30% | Coinsurance after Deductible |
| • Infertility Treatment ⁸ • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder | | |
| Professional Physician/Surgeon Fee | 30% | Coinsurance after Deductible |
| • Infertility Treatment ⁹ • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder | | |
| Skilled Nursing Facility ⁸ | 30% | Coinsurance after Deductible |
| Hospice Care | No Charge | |
| ⁸ Please refer to the section of the Agreement titled “Infertility Services” for more information. | | |
| ⁹ Services must be billed by a Skilled Nursing Facility Participating Provider. | | |

| Prescription Drug Coverage ¹⁰ | At Participating Providers, You Pay | |
|--|---|------------------------------|
| Preventive Drugs | No Charge | |
| Preferred Generic Drugs | \$5 | Copayment |
| Preferred Brand Drugs | \$65 | Copayment |
| Non-Preferred Brand and Generic Drugs | 30% | Coinsurance after Deductible |
| Brand and Generic Specialty Drugs | 30% | Coinsurance after Deductible |
| Mail-Order Prescription Drugs | Up to a 90-day supply is offered at three times the 30-day prescription Cost Sharing. | |
| ¹⁰ For details, please refer to the Agreement section titled “Prescription Drugs.” Molina will apply any third-party payments, financial assistance, discount, product vouchers, or any other reduction in out-of-pocket expenses made by or on behalf of a member for prescription drugs toward a covered Member's Deductible, Copayment, or Cost Sharing responsibility, or Annual Out-of-Pocket Maximum associated to the Member's Plan. | | |

| Ancillary Services | At Participating Providers, You Pay | |
|---|--|------------------------------|
| Durable Medical Equipment | 30% | Coinsurance after Deductible |
| Home Health Care ¹¹ | No Charge | |
| • Limited to 100 visits per calendar year; Including Private Duty Nursing | | |

¹¹ 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 ¹² <ul style="list-style-type: none"> • Medically Necessary Emergency Services are covered for both Participating 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. | 30% | Coinsurance after Deductible |
| Emergency Medical Transportation Air Ambulance <ul style="list-style-type: none"> • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers. | 30% | Coinsurance after Deductible |
| ¹² 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. | | |

| Other Services | At Participating Providers, You Pay | |
|---|-------------------------------------|------------------------------|
| Dialysis Services | \$30 | Copayment |
| Hearing Aids¹³ <ul style="list-style-type: none"> • Medically necessary hearing instruments and related services for Members when a hearing care professional prescribes a hearing instrument to augment communication. • Related services such as selection, fitting, and adjustment of ear molds to maintain optimal fit is covered when Medically Necessary. • Limit one per ear every 36 months. • Expenses for hearing aids and related services may not exceed \$2,500 per hearing aid every 24 months. | 30% | Coinsurance after Deductible |
| ¹³ Please refer to the section of the Agreement titled “Hearing Services” for more information. | | |