MOLINA HEALTHCARE OF ILLINOIS, INC.
SCHEDULE OF BENEFITS
Marketplace – Silver 8 250

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	$5,000
Entire Family of 2 or more Members	$10,000
Annual Out of Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$8,000
Entire Family of 2 or more	$16,000
[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]	40%	Coinsurance after Deductible
Urgent Care Services • Services must be provided by a Participating Provider facility.	$60	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 • Includes prenatal and first postpartum exam	No Charge	
Primary Care (PCP) and Other Practitioner Care • Includes allergy testing	$40	Copayment per visit

Specialty Care • Including consultant and second opinion services	$80	Copayment per visit
Habilitative Services	$40	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.	$40	Copayment per visit
Chiropractic and Osteopathic Manipulation • 25 visits per calendar year	$40	Copayment per visit
Mental/Behavioral Health Services[#]	$40	Copayment per visit
Substance Abuse Disorder Services[#]	$40	Copayment per visit
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 *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	40%	Coinsurance after Deductible
Facility	40%	Coinsurance after Deductible
Infusion Therapy	40%	Coinsurance after Deductible
Dental Services Related to Accidental Injury	40%	Coinsurance after Deductible
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)[7]	40%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	40%	Coinsurance after Deductible
Laboratory Tests	40%	Coinsurance after Deductible
[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) • Infertility Treatment[8] • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder	40%	Coinsurance after Deductible
Professional Physician/Surgeon Fee • Infertility Treatment[9] • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder	40%	Coinsurance after Deductible
Skilled Nursing Facility[8]	40%	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	$20	Copayment
Preferred Brand Drugs	$40	Copayment
Non-Preferred Brand and Generic Drugs	$80	Copayment after Deductible
Brand and Generic Specialty Drugs	$350	Copayment 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	40%	Coinsurance after Deductible
Home Health Care[11] • Limited to 100 visits per calendar year; Including Private Duty Nursing	No Charge	

[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] • 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.	40%	Coinsurance after Deductible
Emergency Medical Transportation Air Ambulance • Medically Necessary Emergency Services are covered for both Participating and Non-Participating Providers.	40%	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	$80	Copayment
Hearing Aids[13] • 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.	40%	Coinsurance after Deductible
[13] Please refer to the section of the Agreement titled "Hearing Services" for more information.		