CONSTANT CARE SILVER 1 150 PLAN

MOLINA HEALTHCARE OF WISCONSIN, INC.
SCHEDULE OF BENEFITS

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE BENEFITS COVERAGE. IT 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.

NOTICE: THIS PRODUCT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. THIS COVERAGE IS AVAILABLE IN THE MARKETPLACE. IT CAN BE PURCHASED AS A STAND-ALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR THE FEDERALLY FACILITATED MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL SERVICES PRODUCT.

In general, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider for Emergency Services and for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$750
Entire Family of 2 or more Members	$1,500
Prescription Drug Deductible	
Individual	N/A
Entire Family of 2 or more Members	N/A
Annual Out-of-Pocket Maximum(OOPM) [1]	**At Participating Providers, You Pay**
Individual	$2,700
Entire Family of 2 or more Members	$5,400

[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your annual OOPM.

Emergency and Urgent Care Services [2]	**You Pay**	
Emergency Services [3]	25%	Coinsurance after deductible
Urgent Care Services – Services must be provided by a Participating Provider	$5	Copayment per visit

[2] Please note: You may be responsible for provider charges that exceed the allowed amount covered under this benefit for emergency services rendered by a Non-Participating Provider. 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.

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Outpatient Professional Services[4]		At Participating Providers, You Pay	
Office Visits[5]			
Preventive Care (Includes prenatal and postpartum exams)		No Charge	
Primary Care (PCP) and Other Practitioner Care		$5	Copayment per visit
Specialty Care		$30	Copayment per visit
Habilitative Services		25%	Coinsurance after deductible
Rehabilitative Services (Limited to 60 days per calendar year)		25%	Coinsurance after deductible
Manipulative Treatment Services		$5	Copayment per visit
Autism Spectrum Disorder Services		$5	Copayment per visit
Mental Health Services		$5	Copayment per visit
Substance Abuse Services		$5	Copayment per visit
Dental Services Related to Accidental Injury		25%	Coinsurance after deductible
Family Planning		No Charge	
Pediatric Vision Services (for Members under age 19 only)			
Vision Exam (Screening and exam, limited to 1 exam each calendar year)		No Charge	
Prescription Glasses			
Frames	• Limited to 1 pair of frames every calendar year • Limited to a selection of covered frames	No Charge	
Lenses	• Limited to 1 pair of prescription lenses every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, UV protection	No Charge	
Prescription Contact Lenses In lieu of prescription glasses, limited to 1 pair of standard contact lenses every calendar year. 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	

[4]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.

[5] 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 at a separate location, even if on the same day as an office visit.

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Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Outpatient Surgical and Non-Surgical Services		
Professional	25%	Coinsurance after deductible
Facility	25%	Coinsurance after deductible
Specialized Scanning Services[6] (e.g., CT Scan, PET Scan, MRI)	25%	Coinsurance after deductible
Radiology Services (e.g., X-Rays)	25%	Coinsurance after deductible
Laboratory Tests	$10	Copayment
Mental Health (Outpatient Intensive Psychiatric Treatment Programs)	25%	Coinsurance after deductible
Inpatient Hospital Services	**At Participating Providers, You Pay**	
Medical / Surgical		
Professional	25%	Coinsurance after deductible
Facility	25%	Coinsurance after deductible
Maternity Care (Professional and Facility Services)	25%	Coinsurance after deductible
Mental Health (Inpatient Psychiatric Hospitalization)	25%	Coinsurance after deductible
Substance Abuse		
Inpatient Detoxification	25%	Coinsurance after deductible
Transitional Residential Recovery Services	25%	Coinsurance after deductible
Skilled Nursing Facility (Limited to 30 days per calendar year) (Services must be billed by a Skilled Nursing Facility Participating Provider)	25%	Coinsurance after deductible
Hospice Care	No Charge	
Prescription Drug Coverage[7]	**At Participating Providers, You Pay**	
Tier-1: Preferred Generic Drugs	$5	Copayment
Tier-2: Preferred Brand Drugs	$30	Copayment
Tier-3: Non-Preferred Brand and Generic Drugs	40%	Coinsurance
Tier-4: Brand and Generic Specialty (Oral and Injectable) Drugs (Maximum Cost Sharing of $100 for a 30-day supply of oral chemotherapy drugs)	40%	Coinsurance
Tier-5: Preventive Drugs	No Charge	
Mail-Order Prescription Drugs (Applies only to Drug Tiers 1, 2, 3 & 5.)	A 90-day supply is offered at two times the 30-day prescription Cost Sharing.	

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

[7]For details, please refer to the EOC section titled "Prescription Drug Coverage."

Please note, Cost Sharing 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 Plan.

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Ancillary Services	**At Participating Providers, You Pay**	
Durable Medical Equipment	25%	Coinsurance
Home Healthcare (Limited to 60 visits per calendar year) (Services must be billed by a Home Healthcare Participating Provider agency)	No Charge	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	25%	Coinsurance
Hearing Aids (Limited to 1 device per ear every 3 years)	25%	Coinsurance
Other Services	**At Participating Providers, You Pay**	
Dialysis Services	$30	Copayment