MOLINA MARKETPLACE

2014

Molina Healthcare of Florida, Inc. Agreement and
Individual Evidence of Coverage

Molina Marketplace – Silver 200 Plan

Florida

8300 NW 33 St., Suite 400
Doral, FL 33122

Officer's Signature
David Pollack, Plan President

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN 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 PLAN 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.

MHF01012014

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MHF01012014

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This Molina Healthcare of Florida, Inc. Agreement and Individual Evidence of Coverage (also called the "**EOC**" or "**Agreement**") is issued by Molina Healthcare of Florida, Inc. ("**Molina Healthcare**", "**Molina**", "**we**", or "**our**"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina Healthcare agrees to provide the Benefits and Coverage as described in this Agreement.

This Agreement, amendments to this Agreement, and any application(s) submitted to Molina Healthcare and/or the Marketplace to obtain coverage under this Agreement , including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the legally binding contract between Molina Healthcare and the Subscriber.

WELCOME

Welcome to Molina Healthcare!

Here at Molina Healthcare, we'll help You meet Your medical needs.

If You are a Molina Healthcare Member, this Agreement tells You what services You can get.

Molina Healthcare is a Florida licensed Health Maintenance Organization.

If You have any questions about anything in this Agreement, about Molina Healthcare, or if You need this information in another language, large print, Braille, or audio, You may call or write to us at:

Molina Healthcare of Florida, Inc.
Customer Support Center
PO Box 527450
Miami, Florida 33152-1838
1 (888) 560-5716
www.molinahealthcare.com

If You are deaf or hard of hearing You may contact us through our dedicated TTY line, toll-free, at 1 (800) 955-8771 by dialing 711 for the National Relay Service.

MOLINA HEALTHCARE OF FLORIDA, INC.
BENEFITS AND COVERAGE GUIDE

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF FLORIDA, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS.

Deductible Type	You Pay
Medical Deductible (Applies only to outpatient and inpatient hospital/facility services)	
Individual	$1,500
Entire Family of 2 or more	$3,000
Other Deductibles	
Prescription Drug Deductible[(Applies to Non-Preferred Brand and Specialty Drugs)	
Individual	$0
Entire Family of 2 or more	$0

Annual Out of Pocket Maximum	You Pay
Individual	$5,200
Entire Family of 2 or more	$10,400

Emergency Room and Urgent Care Services	You Pay	
Emergency Room*	$250	Copayment per visit
Urgent Care	$60	Copayment per visit

*This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital Services, for applicable Cost Sharing to You)

Outpatient Professional Services**	You Pay	
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$30	Copayment per visit
Specialty Care	$60	Copayment per visit
Other Practitioner Care	$60	Copayment per visit

Habilitative Services	30%	Coinsurance
Rehabilitative Services	30%	Coinsurance
Mental/Behavioral Health Services	$60	Copayment per visit
Substance Abuse Disorder Services	$60	Copayment per visit
Dental Services Related to Accidental Injury	30%	Coinsurance
Pediatric Vision Services (for Members under Age 19 only)		
Routine Vision Exam (screening and exam, limited to 1 exam each calendar year)	No Charge	
Prescription Glasses Standard Lenses (limited to 1 pair of prescription lenses every 12 months) Standard Frames (1 pair of frames every 12 months)	No Charge	
Standard Contact Lenses (limited to 1 pair once every 12 months, in lieu of prescription glasses) as Medically Necessary for specified medical conditions	No Charge	
Low Vision Optical Devices and Services (subject to limitations and Prior Authorization applies)	30%	Coinsurance
Family Planning	No Charge	

****General medical care provided by a Participating Provider**

Outpatient Hospital / Facility Services	**You Pay**	
Outpatient Surgery		
Professional	30%	Coinsurance
Facility	30%	Coinsurance
Specialized Scanning Services		
CT Scan	30%	Coinsurance
PET Scan	30%	Coinsurance
MRI	30%	Coinsurance
Radiology Services	$60	Copayment
Laboratory Tests	$30	Copayment

Mental/Behavioral Health		
Outpatient Intensive Psychiatric Treatment Programs	$60	Copayment
Inpatient Hospital / Facility Services		**You Pay**
Medical / Surgical		
Professional	30%	Coinsurance
Facility	30%	Coinsurance
Maternity Care (professional and facility services)	30%	Coinsurance
Mental/Behavioral Health (Inpatient Psychiatric Hospitalization)	30%	Coinsurance
Substance Abuse Disorder		
Inpatient Detoxification	30%	Coinsurance
Transitional Residential Recovery Services	30%	Coinsurance
Skilled Nursing Facility	30%	Coinsurance
Hospice Care	0%	Coinsurance

Prescription Drug Coverage		You Pay
Formulary Generic Drugs	$15	Copayment
Formulary Preferred Brand Drugs	$40	Copayment
Formulary Non-Preferred Brand Drugs	30%	Coinsurance
Specialty Drugs (Oral and Injectable Drugs)	30%	Coinsurance

Please refer to Page 57 for a description of benefit limitations and applicable exceptions.

Ancillary Services		You Pay
Durable Medical Equipment	30%	Coinsurance
Home Health Care	$60	Copayment per visit
Emergency Medical Transportation (Ambulance)	$250	Copayment

Non-Emergency Medical and Non-Medical Transportation (Combined limit of 4 round trips per month)	$10	Copayment per round trip

Other Services	**You Pay**	
Dialysis Services	$60	Copayment

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.

This document is called Your "Molina Healthcare of Florida, Inc. Agreement and Individual Evidence of Coverage" (Your "Agreement" or "EOC"). The Agreement tells You how You can get services through Molina Healthcare. It also sets out the terms and conditions of coverage under this Agreement, Your rights and responsibilities as a Molina Healthcare Member and how to contact Molina Healthcare. Please read this EOC completely and carefully and keep it in a safe place where You can get to it quickly. If You have special health care needs, carefully read the sections that apply to You.

Molina Healthcare is here to serve You.

Call Molina Healthcare if You have questions or concerns. Our helpful and friendly staff will be happy to help You. We can help You choose a doctor, or make an appointment or arrange for an interpreter. We can also listen and respond to Your questions (or complaints!) about Your benefits, Molina Healthcare, Your doctor, or any other Molina Healthcare services.

Call us toll-free at 1 (888) 560-5716 between 8:00 a.m. to 7:00 p.m. ET Monday through Friday. If You are deaf or hard of hearing, You may contact us through our dedicated TTY line toll-free at 1 (800) 955-8771 or by dialing 711 for the National Relay Service.

If You move from the address You had when You enrolled with Molina Healthcare or change phone numbers, please contact our Customer Support Center to update that information.

Sharing Your updated address and phone number with Molina Healthcare will help us get information to You. This will allow us to send newsletters and other materials, or to reach You by phone if we need to contact You.

YOUR PRIVACY

Your privacy is important to us. We respect and protect Your privacy. Molina Healthcare uses and shares Your information to provide You with health benefits. Molina Healthcare wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?

Molina Healthcare needs Your written approval to use or share Your PHI for purposes not listed above.

What are Your privacy rights?

- To look at Your PHI
- To get a copy of Your PHI
- To amend Your PHI
- To ask us to not use or share Your PHI in certain ways
- To get a list of certain people or places we have given Your PHI

How does Molina Healthcare protect Your PHI?

Molina Healthcare uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. Our Notice of Privacy Practices is in the following section of this EOC and is on our web site at www.molinahealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Customer Support Center at 1 (888) 560-5716.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF FLORIDA, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Florida, Inc. ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

PHI stands for these words, protected health information. PHI means health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment
Molina Healthcare may use or share Your PHI to give You, or arrange for, Your medical care. This treatment also includes referrals between Your doctors or other health care providers. For example, we may share information about Your health condition with a specialist. This helps the specialist talk about Your treatment with Your doctor.

For Payment
Molina Healthcare may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, Your condition, Your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that You have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations
Molina Healthcare may use or share PHI about You to run our health plan. For example, we may use information from Your claim to let You know about a health program that could help You. We may also use or share Your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address Member needs, including solving complaints and grievances.

We will share Your PHI with other companies ("**business associates**") that perform different kinds of activities for our health plan. We may also use Your PHI to give You reminders about Your appointments. We may use Your PHI to give You information about other treatment, or other health-related benefits and services.

When can Molina Healthcare use or share Your PHI without getting written authorization (approval) from You?
The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes including the following:

Required by Law
We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health
Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight
Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

Research
Your PHI may be used or shared for research in certain cases.

Law Enforcement
Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety
Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions
Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence
Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation
Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures
Your PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a

written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave to us.

What are Your health information rights?

You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask us not to share Your PHI to carry out treatment, payment or health care operations. You may also ask us not to share Your PHI with family, friends or other persons You name who are involved in Your health care. However, we are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep Your PHI private. We will follow reasonable requests, if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases we may deny the request. *Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.*

- **Amend Your PHI**
  You may ask that we amend (change) Your PHI. This involves only those records kept by us about You as a Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. You may file a letter disagreeing with us if we deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that we give You a list of certain parties that we shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:

  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with Your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - PHI released in the interest of national security or for intelligence purposes; or
  - as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if You ask for this list more than once in a 12-month period. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Customer Support Center at 1 (888)-560-5716.

What can You do if Your rights have not been protected?
You may complain to Molina Healthcare and to the Department of Health and Human Services if You believe Your privacy rights have been violated. We will not do anything against You for filing a complaint. Your care and benefits will not change in any way.

You may complain to us at:

Customer Support Center
PO Box 527450
Miami, Florida 33152-1838
1 (888) 560-5716

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, Georgia 30303
1 (800) 368-1019; 1 (800) 537-7697 (TDD)
1 (404) 562-7881 (FAX)

What are the duties of Molina Healthcare?
Molina Healthcare is required to:

- Keep Your PHI private;
- Give You written information such as this on our duties and privacy practices about Your PHI;
- Provide You with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

If You have any questions, please contact the following office:

Customer Support Center
PO Box 527450

Miami, Florida 33152-1838
1 (888) 560-5716
www.molinahealthcare.com

HELP FOR NON-ENGLISH SPEAKING MOLINA HEALTHCARE MEMBERS

Interpreter Services
As a Molina Healthcare Member, You have access to interpreter services.

You do not need to have a minor, friend or family member act as Your interpreter. You may wish to say things that You do not wish to share with a minor, friend or family member. Using an interpreter may be better for You. Please call the Customer Support Center toll-free at 1 (888) 560-5716.

How do I use interpreter services?

- For Your doctor's office or clinic visits
- Labs, clinics, or other medical service offices
- The pharmacy where You get Your medicine
- The emergency room at a hospital

The office or pharmacy may have a staff person who speaks Your language. If they do not, they will call the Customer Support Center toll-free at 1 (888) 560-5716 for telephonic interpreter services. You will be able to discuss and get the information You need using the telephone interpreter.

Call us if You have any questions.
Customer Support Center toll-free at: 1 (888)-560-5716.

If You are deaf or hard of hearing You may contact us through our dedicated TTY line, toll-free, at 1 (800) 955-8771 or by dialing 711 for the National Service.

If You need help understanding the enclosed information in Your language, please call Molina Healthcare Customer Support at 1-(888) 560-5716.

DEFINITIONS

Some of the words used in this EOC do not have their usual meaning. Health plans use these words in a special way. When we use a word with a special meaning in only one section of this EOC, we explain what it means in that section. Words with special meaning used in any section of this EOC are explained in this "Definitions" section.

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"**Annual Out-of-Pocket Maximum**" is the total amount of Cost Sharing You may have to pay for Covered Services in a calendar year. The Annual Out-of-Pocket Maximum is specified in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. The Annual Out-of-Pocket Maximum includes payments You have made towards the Deductible, Copayments, and Coinsurance.

"**Authorization or Authorized**" means a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP, medical group or Molina Healthcare. An Authorization is usually called an "approval."

"**Benefits and Coverage**" (also referred to as "**Covered Services**") means the healthcare services that You are entitled to receive from Molina Healthcare under this Agreement.

"**Coinsurance**" is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

"**Complications of Pregnancy**" is a condition diagnosed as separate from a pregnancy. Complications means a condition, requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, therapeutic abortion, non-elective caesarean section, tubal pregnancy which is terminated; miscarriages; or medical and surgical conditions of similar severity. Complications of pregnancy do not include false labor, occasional spotting, healthcare professional prescribed bed rest during the period of pregnancy, morning sickness, uncontrolled vomiting; convulsions and high blood pressure; or similar conditions associated with a difficult pregnancy.

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

"**Cost Sharing**" is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide at the beginning of this EOC.

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive

before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Please refer to the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible. When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in this Agreement.

"**Drug Formulary**" is Molina Healthcare's list of approved drugs that doctors can order for You.

"**Durable Medical Equipment**" is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to You in the absence of illness or injury and does not include accessories primarily for Your comfort or convenience. Examples include, without limitation: oxygen equipment, blood glucose monitors, apnea monitors, nebulizer machines, insulin pumps, wheelchairs and crutches.

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in 1) placing the health of the Member in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman, "**Emergency**" or "**Emergency Medical Condition**" also means: a) that there is inadequate time to effect safe transfer to another hospital prior to delivery; b) that a transfer may pose a threat to the health and safety of the patient or fetus; or c) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

"**Emergency Services**" mean medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a physician necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a hospital.

"**Essential Health Benefits**" or "**EHB**" means a standardized set of essential health benefits that are required to be offered by Molina Healthcare to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care

- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

*Pediatric dental services can be separately purchased through a stand-alone dental plan that is certified by the Marketplace.

"**Experimental or Investigational**" means any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

"**Marketplace**" means a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Florida buy qualified health plan coverage from insurance companies or health plans such as Molina Healthcare. The Marketplace may be run as a state-based marketplace, a federally-facilitated marketplace or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of Florida, however, it may be organized and run.

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1) In accordance with generally accepted standards of medical practice;

2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

3) Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

"**Member**" means an individual who is eligible and enrolled under this Agreement, and for whom we have received applicable Premiums. The term includes a Subscriber and a Dependent. This Agreement sometimes refers to a Member as "You" or "Your."

"**Molina Healthcare of Florida, Inc. Agreement and Individual Evidence of Coverage**" means this booklet, which has information about Your benefits. It is also called the "EOC" or "Agreement."

"**Molina Healthcare of Florida, Inc. ("Molina Healthcare" or "Molina")**" means the corporation licensed by Florida as a Health Maintenance Organization, and contracted with the

Marketplace. This Agreement sometimes refers to Molina Healthcare as “we” or “our.”

“**Non-Participating Provider**” refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Members.

“**Other Practitioner**” refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians. Other Practitioners include, without limitation, nurses, physician assistants, nurse-midwives.

“**Participating Provider**” refers to those providers, including hospitals, physicians and Other Practitioners, that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

“**Premiums**” mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

“**Primary Care Doctor**” (also a “**Primary Care Physician**” and “**Personal Doctor**”) is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to specialists or other services. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctors who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).
- Osteopathic physicians
- Podiatrist
- Chiropractor

“**Primary Care Provider**” or “**PCP**” means 1) a Primary Care Doctor, or 2) individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor.

“**Referral**” means the process by which the Member’s Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

“**Service Area**” means the geographic area in the State of Florida where Molina Healthcare has been authorized by the Florida Office of Insurance Regulation to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

“**Specialist Physician**” means any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

“**Spouse**” means the Subscriber’s legal husband or wife. For purposes of this Agreement, the term “Spouse” includes the Subscriber’s same-sex spouse if the Subscriber and spouse are a couple who are registered domestic partners who meet all the requirements of Florida law (including county, city, and municipal laws), sometimes referred to as a “Domestic Partnership”

herein.

"**Subscriber**" means an individual who is a resident of the State of Florida, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare in accord with the terms of this Agreement.

"**Urgent Care Services**" mean those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

ELIGIBILITY AND ENROLLMENT

When Will My Molina Healthcare Membership Begin?
Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements and are accepted by Molina Healthcare and/or the Marketplace.

For coverage during the calendar year 2014, the initial open enrollment period begins October 1, 2013 and ends March 31, 2014. Your Effective Date for coverage during 2014 will depend on when You applied:

- If You applied on or before December 15, 2013, the Effective Date of Your coverage is January 1, 2014.
- If You applied between the first of the month and 15th of the month during the months of January, February or March 2014, the Effective Date of Your coverage is the first day of the following month.
- If You applied between the 16th of the month and the end of the month during the months of January, February or March 2014, the Effective Date of Your coverage is the first day of the second following month.

For coverage during the calendar year 2015, and every year thereafter, the annual open enrollment period will begin on October 15th and end on December 7th of the preceding calendar year. The Effective Date of coverage will be January 1 immediately following the open enrollment period.

If You fail to enroll during an open enrollment period, You may be able to enroll during a special enrollment period for which You are determined eligible in accordance with the special enrollment procedures established by the Marketplace and/or Molina Healthcare. In such case, the Effective Date of coverage will be as determined by the Marketplace. Without limiting the above, the Marketplace and Molina Healthcare will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

The Effective Date for coverage of new Dependents is described below in the section titled "Adding New Dependents."

Who is Eligible?
To enroll and continue enrollment, You must meet all of the eligibility requirements established by the Marketplace. Check the Marketplace's website for eligibility criteria. Molina Healthcare requires You to live or work in Molina Healthcare's Service Area for this product. If You have lost Your eligibility, as described in the section titled "When Will My Molina Healthcare

Membership End? (Termination of Benefits and Coverage)", You may not be permitted to re-enroll.

Dependents: Subscribers who enroll in this product during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Molina Healthcare requires Dependents to live or work in Molina Healthcare's Service Area for this product. The following types of family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren do not qualify as Dependents of the Subscriber.

Age Limit for Children (Disabled Children): Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

Molina Healthcare will provide the Subscriber with notice at least 90 days prior to the date the Subscriber's enrolled child reaches the limiting age at which the dependent child's coverage will terminate. The Subscriber must provide Molina Healthcare with proof of his or her child's incapacity and dependency within 60 days of the date of receiving such notice from Molina Healthcare in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina Healthcare.

A disabled child may remain covered by Molina Healthcare as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

Continued Eligibility of Certain Children Beyond the Limiting Age of 26: Dependent children are eligible to continue enrollment from the end of the calendar year in which the child turns age twenty-six (26) until the end of the calendar year in which the child turns thirty (30) years of age, if the child meets all of the following requirements:

- is unmarried and does not have a dependent of his or her own;
- is a resident of Florida or a full time or part time student; and
- is not provided coverage as a named Subscriber, insured, enrollee, or a covered person under any other group or individual health benefit plan or is not entitled to benefits under Title XVIII of the Social Security Act.

If a Dependent child is provided coverage under the Agreement after the child reaches age twenty-six (26) and the coverage for the child is subsequently terminated prior to the end of the calendar year in which the child turns age thirty (30), the child is ineligible to be covered again under the Agreement unless the child was continuously covered by other creditable coverage without a coverage gap of more than sixty-three (63) days.

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber are enrolled (such as a new Spouse, a newborn child or a newly adopted child), You must contact Molina Healthcare and/or the Marketplace and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to Molina Healthcare and/or the Marketplace within 60 days from the date the Dependent became eligible to enroll with Molina Healthcare.

- **Spouse**: You can add a Spouse as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:
  - The Spouse loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" in compliance with under the Affordable Care Act.
  - The date of Your marriage or the date the registration of Domestic Partnership is filed with the appropriate governmental entity in the State of Florida that authorizes and registers Domestic Partnerships;
  - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.
- **Children Under 26 Years of Age:** You can add a Dependent under the age 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:
  - The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act;
  - The child becomes a Dependent through marriage**,** Domestic Partnership, birth, or adoption;
  - The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
- **Newborn Child:** Coverage for a newborn child is from the moment of birth and will continue for 31 days (including the date of birth). If You enroll the newborn child within 31 days of birth, no additional Premium will be charged for the first 31 days. If You fail to enroll the newborn child within 31 days of birth, but enroll the child within 60 days of the birth, the child will be covered from the date of birth and You will be required to pay Premium for the child from the date of birth. If the newborn child is not enrolled within sixty 60 days of birth, the child can be enrolled during the next open enrollment period, as determined by the Marketplace.
- **Newborn Child of a Covered Family Member (Other than Spouse):** Coverage for a newborn child of a Covered Dependent child who is enrolled before the end of the Calendar Year in which the Covered Dependent child turns age 26 is covered for a period of 18 months from birth if the newborn child is enrolled within 60 days of birth.
- **Adopted Child:** Coverage for a newly adopted child (including a newborn adopted child) or child placed with You or Your Spouse for adoption, is the date of adoption or

placement for adoption or when You or Your Spouse gain the legal right to control the child's health care, whichever is earlier. However, if You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days (including the date of adoption placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier). For purposes of this requirement, "legal right to control health care" means You or Your Spouse have a signed written document (such as a health facility minor release report, a medical authorization form, or a relinquishment form) or other evidence that shows You or Your Spouse have the legal right to control the child's health care.

Proof of the child's date of birth or qualifying event will be required.

Discontinuation of Dependent Benefits and Coverage: Benefits and Coverage for Your Dependent will be discontinued on:

- The date the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)," above, for more information.
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage, or termination of the Domestic Partnership from the Subscriber.

Continued Eligibility: A Member is no longer eligible for this product if:

- The Member becomes abusive or violent and threatens the safety of anyone who works with Molina Healthcare, including Participating Providers.

- The Member substantially impairs the ability of Molina Healthcare, or anyone working with Molina Healthcare, including Participating Providers, to provide care to the Member or other Members.

- There is a breakdown in the Member's relationship with the Member's doctor and Molina Healthcare does not have another doctor for the Member to see. This may not apply to Members refusing medical care.

If You are no longer eligible for this product, we will send You a letter letting You know at least 10 days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

MEMBER IDENTIFICATION CARD

How Do I Know if I am a Molina Healthcare Member?
You get a Member identification (ID) card from Molina Healthcare. Your ID card comes in the mail. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call Molina Healthcare toll-free at 1 (888)-560-5716. We will be happy to send You a new card.

If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-5716.

What Do I Do First?
Look at Your Molina Healthcare Member ID card. Check that Your name and date of birth are correct. Your card will tell You the name of Your doctor. This person is called Your Primary Care Doctor or PCP. This is Your main doctor. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of Birth (DOB)
- Your Primary Care Doctor's name (Provider)
- Your Primary Care Doctor's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- Molina Healthcare's 24 hours Nurse Advice Line toll-free number
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions and the identifier for Molina Healthcare's prescription drug benefit
- Toll free number for hospitals to notify Molina Healthcare of admissions for our Members
- Toll free number for emergency rooms to notify Molina Healthcare of emergency room admissions for our Members

Your ID card is used by health care providers such as Your Primary Care Doctor, pharmacist, hospital and other health care providers to determine Your eligibility for services through Molina Healthcare. When accessing care You may be asked to present Your ID card before services are provided.

ACCESSING CARE

How Do I Get Medical Services Through Molina Healthcare?
(Choice of Doctors and Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS' HEALTH CARE SERVICES MAY BE OBTAINED.

Your Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina Healthcare. You may visit Molina Healthcare's website at www.molinahealthcare.com to view our online list of the Participating Providers or call our Customer Support Center to request a paper copy.

The first person You should call for any healthcare is Your Primary Care Provider.

If You need hospital or similar services, You must go to a facility that is a Participating Provider. For more information about which facilities are with Molina Healthcare or where they are located, call Molina Healthcare toll-free at 1 (888) 560-5716. You may get Emergency Services or out of area Urgent Care Services in any emergency room or urgent care center, wherever located.

Here is a chart to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. Find the service You need, look in the box just to the right of it and You will find out where to go.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
Emergency Care	Call 911 or go to the nearest emergency room. Even when outside Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	For directions, call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. For out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
• Birth control • Sterilization	
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor).	Women may go to any Participating Provider OB/GYN without a Referral or Prior Authorization. Ask Your doctor or call Molina Healthcare's Customer Support Center if You do not know an OB/GYN.
To see a specialist (for example, cancer or heart doctor)	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above
To have surgery	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above
To get a second opinion	Consult Your Provider Directory on our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate care center. You can also call Molina Healthcare's Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. You also have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free 1 (888)-560-5716.

What is a Primary Care Provider?

A Primary Care Provider (or PCP) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

You may think that You should not see Your PCP until You are sick. That is not true.

Get to know Your PCP even when You are well. Go for yearly check-ups to stay healthy. Go to Your PCP for check-ups, tests and test results, shots, and – of course – when You are ill. Seeing Your PCP for check-ups allows problems to be found early. If You need special care, Your PCP

will help You get it. Your PCP and You work together to keep You healthy.

If You want to know more about Your PCP or other Molina Healthcare doctors, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-5716.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this product, Your health care services must be received from Molina Healthcare Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of Emergency Services or out of area Urgent Services. Please see page 26 for more information about the coverage of Emergency Services and out of area Urgent Services.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina Healthcare's health plan. You will also learn some helpful tips on how to use Molina Healthcare's services and benefits. Your Provider Directory was included in the materials You received from Molina Healthcare. If You did not get a Provider Directory, then please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-5716.

You can find the following in Your Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations

You can also find whether or not a Participating Provider, including doctors, hospitals, specialists, or medical clinics, is accepting new patients in Your Provider Directory.

Note: Some hospitals and providers may not provide some of the services that may be covered under this Agreement that You or Your family member might need: family planning, birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should obtain more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 560-5716 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider (PCP)?
It's easy to choose a Primary Care Provider (or PCP). Simply use our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for Yourself and another one for Your family members.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You choose a PCP that You feel comfortable with.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina Healthcare toll-free at 1 (888)-560-5716. Molina Healthcare can also help You find a PCP. Tell us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina

Healthcare doctor.

What if I Don't Choose a Primary Care Provider?
Molina Healthcare asks that You select a Primary Care Provider within 30 days of joining Molina Healthcare. However, if You don't choose a PCP, Molina Healthcare will choose one for You.

Changing Your Doctor

What if I Want to Change my Primary Care Provider?
You can change Your PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month. But first visit Your doctor. Get to know Your PCP before changing. Having a good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina Healthcare doctor.

Can my Doctor Request that I Change to a Different Primary Care Provider?
Your doctor may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How Do I Change my Primary Care Provider?
Call Molina Healthcare toll-free at 1 (888) 560-5716, Monday through Friday, 8:00 a.m. to 7:00 p.m. ET. You may also visit Molina Healthcare's website at www.molinahealthcare.com to view our online list of doctors. Let us help You make the change.

Sometimes You may not be able to get the PCP You want. This may happen because:

- The PCP is no longer a Participating Provider with Molina Healthcare.
- The PCP already has all the patients he or she can take care of right now.

What if my Doctor or Hospital is no Longer with Molina Healthcare?
If Your doctor (PCP or specialist) or a hospital is no longer with Molina Healthcare, we will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. Our Molina Healthcare Customer Support Center staff can help You make a choice.

If You are assigned to a PCP or hospital that is ending a contract with Molina Healthcare, then Molina Healthcare will provide You 60 days advance written notice of such a contract ending between Molina Healthcare and PCP or acute care hospital.

Continuity of Care

If You are actively receiving treatment at the time that Your doctor's contract with Molina Healthcare ends, then You may continue coverage and care with that doctor when Medically Necessary, until completion of treatment, until You select another doctor who is a Participating Provider, or until the next open enrollment period, whichever is longer, but not longer than 6

months after Your doctor's contract with Molina Healthcare has ended. If You are pregnant and You have initiated a course of prenatal care, regardless of the trimester in which care was initiated, You may continue coverage with the doctor until You complete postpartum care.

Eligibility for continuity of care is not based strictly upon the name of Your condition.

Your doctor may refuse to continue to provide care to a Member who is abusive, noncompliant, or in arrears in payments for services provided.

Your doctor or the hospital may not agree to continue to provide You services or may not agree to comply with Molina Healthcare's contractual terms and conditions that are imposed on Participating Providers. If that happens, Molina Healthcare will assign You to a new doctor or send You to a new hospital for care.

If You want to request that You stay with the same doctor or hospital for continuity of care, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-5716. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 955-8771 or by dialing 711 for the National Relay Service.

Please note that the right to temporary continuity of care, as described above, does not apply to a newly enrolled Member undergoing treatment from a doctor or hospital that is not a Participating Provider with Molina Healthcare.

24-Hour Nurse Advice Line

If You have questions or concerns about You or Your family's health, call our 24-Hour Nurse Advice Line at 1 (888) 560-5716 or, for Spanish, at 1 (866) 648-3537. If You are deaf or hard of hearing access Nurse Advice with the National Relay Service by dialing 711. The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

What is a Prior Authorization?

A **Prior Authorization** is a request for You to receive a Covered Service from Your doctor. Molina Healthcare's Medical Directors and Your doctor review the Medical Necessity of Your care before the care or service is given to ensure it is appropriate for Your specific condition.

You do not need Prior Authorization for the following services:

- Emergency or Urgent Care Services
- Female Members may self-refer to an OB/GYN
- Family planning services
- Human Immunodeficiency Virus (HIV) testing & counseling
- Services for sexually transmitted diseases
- Spinal Manipulation Therapy
- Podiatry Services
- Dermatological Services (up to 5 office visits per year without Prior Authorization)

You must get Prior Authorization for the following services, among others
(except when for Emergency Services and Urgent Care Services)**:**

- All inpatient admissions
- Cardiac and pulmonary rehabilitation
- Certain high dollar injectable drugs and medications not listed on the Molina Drug Formulary)
- Cosmetic, plastic and reconstructive procedures
- Dental general anesthesia for dental care in Members 8 years old or older
- Dialysis – notification only
- Durable Medical Equipment that costs more than $500
- All customized orthotics / prosthetics and braces (for example special braces, shoes or shoe supports) wheelchairs (for example manual, electric or scooters) and internally implanted hearing devices
- Enteral formulas and nutritional supplements and related supplies
- Experimental and Investigational procedures
- Habilitative services
- Home health care
- Hospice inpatient care – notification only
- Imaging (special testing such as CT (computed tomography), MRI (magnetic resonance imaging), MRA (magnetic resonance angiogram), cardiac scan and PET (positron emission tomography) scan)
- Mental/behavioral health services
- Office based podiatry (foot) surgery
- Outpatient hospital / ambulatory surgery center procedures subject to exceptions*
- Pain management services and procedures
- Pregnancy and delivery – notification only
- Rehabilitative services
- Specialty pharmacy
- Substance abuse disorder services
- Transplant evaluation and related services
- Transportation (non-emergent Medically Necessary ground and air ambulance, for example – medi-van, wheel chair van, ambulance, etc.)
- Any other services listed as requiring Prior Authorization in this Agreement

*Call Molina Healthcare's Customer Support Center at 1 (888)-560-5716 if You need to determine if Your service needs Prior Authorization.

If Molina Healthcare denies a request for Prior Authorization , You may appeal that decision as described below. If You or Your provider decide to proceed with services that have been denied a Prior Authorization for benefits under this product, You may be responsible for the charges for the denied services.

Approvals are given based on medical need. If You have questions about how a certain service is approved, call Molina Healthcare toll-free at 1 (888) 560-5716. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 955-8771 or dial 711 for the National Relay Service. We will be happy to send You a general explanation of how that type of decision is made or send You a general explanation of the overall approval process if You request it.

Request Types	Timeframe for Decision
Pre-Service Authorization	Within 15 days of receipt of the request for services. Molina may

	extend the 15-day period for an additional 15-days because of matters beyond Molina's control. If this is necessary Molina will let You know in writing within the first 15-days. If the delay is because Molina needs more information to make a decision, You will have up to 45-days to provide the needed information.
Concurrent Services Authorization	Within 72 hours of receipt of the request for authorization of services involving Urgent Care Services. For other requests a decision will be made within 15-days.
Post-Service Authorization	Within 30 days of receipt of the request for services. Molina may extend the 30-day period for an additional 15-days because of matters beyond Molina's control. If this is necessary Molina will let You know in writing within the first 30-days. If the delay is because Molina needs more information to make a decision, You will have up to 45-days to provide the needed information.

Medical conditions that may cause a serious threat to Your health are processed within 72 hours from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina Healthcare processes requests for urgent specialty services immediately by telephone.

If a service is not Medically Necessary or is not a Covered Service, request for the service may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are also noted on pages 70 of this Agreement.

Standing Approvals
If You have a condition or disease that requires specialized medical care over a prolonged period of time, You may need a standing approval. If You receive a standing approval to a specialist, You will not need to get a Referral or a Prior Authorization every time You see that specialist. Also, if Your condition or disease is life threatening, worsening, or disabling, You may need to receive a standing approval to a specialist or specialty care center. They have the expertise to treat the condition or disease. To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina Healthcare's physicians and specialists to ensure You receive a treatment plan based on Your medical needs. If You have any difficulty getting a standing approval, call Molina Healthcare toll-free at 1 (888) 560-5716 or call our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 955-8771 or dial 711 for the National Relay Service. If, after calling Molina, You feel Your needs have not been met, please refer to Molina Healthcare's complaint process on page 70.

Second Opinions
You or Your PCP may want another doctor (a PCP or a specialist) to review Your condition. This doctor looks at Your medical record and may see You. This new doctor may suggest a plan of care. This is called a second opinion. In any instance in which You dispute Molina's or a physician's opinion of the reasonableness or necessity of surgical procedures or You are seriously injured or ill, You have a right to seek a second opinion. You may be limited to three second opinion requests per calendar year under this product. Please consult Your Provider Directory on our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.

When You are entitled to a second opinion under this product, You may choose a physician that is a Participating Provider or a Non-Participating Provider. If You choose a physician that is a

Non-Participating Provider, then Molina will pay the amount of all charges which are usual, reasonable, and customary in the community and You will be responsible for a coinsurance payment in the amount of 40%. The tests that are deemed necessary by the physician, whether a Participating or Non-Participating Provider may be conducted in Molina's discretion.

Here are some, but not all the reasons why You may get a second opinion:

- Your symptoms are complex or confusing. Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care for a while and Your health has not improved.
- You are not sure that You need surgery or think You need surgery.
- You do not agree with what Your doctor thinks is Your problem. You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.

Emergency and Urgent Care Services

What is an Emergency?
Emergency Services mean health care services needed to evaluate, stabilize or treat an **Emergency Medical Condition.** An Emergency Condition includes a medical or psychiatric medical condition having acute and severe symptoms (including severe pain) or involving active labor. If immediate medical attention is not received, an Emergency could result in any of the following:

- **Placing the patient's health in serious danger.**
- **Serious damage to bodily functions.**
- **Serious dysfunction of any bodily organ or part.**

Emergency Services also includes Emergency contraceptive drug therapy.

Emergency Services includes Urgent Care Services that cannot be delayed in order to prevent serious deterioration of health from an unforeseen condition or injury.

How do I get Emergency care?

Emergency care is available 24 hours a day, seven days a week for Molina Healthcare Members.

If You think You have an Emergency, wherever You are:

- Call 911 right away.
- Go to the closest hospital or emergency room.

When You go for Emergency health care, carry Your Molina Healthcare Member ID card.

If You are not sure if You need Emergency health care but You need medical help, call Your PCP. Or call our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. The Nurse Advice Line is staffed by registered nurses (RNs). You can call the

Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please use the National Relay Service by dialing 711.

Hospital emergency rooms are only for real Emergencies. These are not good places to get non-Emergency care. They are often very busy and must care first for those whose lives are in danger. Please do not go to a hospital emergency room if Your condition is not an Emergency.

What if I'm away from Molina Healthcare's Service Area and I need Emergency health care?
Go to the nearest emergency room for care. Please contact Molina Healthcare within 24 hours, or when medically reasonable, of getting urgent or Emergency health care. Call toll-free at 1-888-560-5716. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 955-8771 or dial 711 for the National Relay Service. When You are away from Molina Healthcare's Service Area, only Urgent Care Services or Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?
Urgent Care Services are available when You are within or outside of Molina Healthcare's Service Area. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services, for directions, call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. Our nurses can help You any time of the day or night. They will tell You what to do or where to go to be seen.

If You are within Molina Healthcare's Service Area and have already asked Your PCP the name of the urgent care center that You are to use, go to the urgent care center. It is best to find out the name of the urgent care center ahead of time. Ask Your doctor for the name of the urgent care center and the name of the hospital that You are to use.

If You are outside of Molina Healthcare's Service Area, You may also go to the nearest urgent care center or emergency room.

You have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free at 1 (888)-560-5716.

Complex Case Management
What if I have a difficult health problem?

Living with health problems and dealing with the things to manage those problems can be hard. Molina Healthcare has a program that can help. The Complex Case Management program is for Members with difficult health problems who need extra help with their health care needs.

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems and teach You how to better manage them. The nurse may also work with Your family or caregiver and provider to make sure You get the care You need. There are several ways You can be referred for this program. There are also certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll-free at 1 (888) 560-5716 or call our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 955-8771 or dial 711 for the National Relay Service.

Pregnancy

What if I am pregnant?

If You think You are pregnant—or as soon as You know You are pregnant—please call for an appointment to begin Your prenatal care. Early care is very important for You and Your baby's health and well-being.

You may choose any of the following for Your prenatal care:

- Licensed obstetrician/gynecologist (OB/GYN)
- Nurse practitioner (trained in women's health)

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits under this Agreement, You must pick an OB/GYN or nurse practitioner who is a Participating Provider. If You need help choosing an OB/GYN or if You have any questions, call Molina Healthcare toll-free at 1 (888) 560-5716, Monday through Friday from 8:00 a.m. to 7:00 p.m. ET. We will be happy to assist You.

Molina Healthcare offers a special program called Motherhood Matters to our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. For more information, call the Motherhood Matters pregnancy program toll-free at 1 (877) 665-4628, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Accessing Care for Members with Disabilities

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability. The ADA requires Molina Healthcare and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access

Molina Healthcare has made every effort to ensure that our offices and the offices of Molina Healthcare doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at 1 (888) 560-5716 or call our dedicated TTY line toll-free at 1 (800) 955-8771 and a Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing

Let us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. It is our goal to have an interpreter meet You at the doctor's office. Call Molina Healthcare's Customer Support Center through our TTY Number toll-free at 1 (800) 955-8771, or dial 711 for the National Relay Service.

Access for Persons with Low Vision or who are Blind

This Agreement and other important plan materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are

available and this Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Molina Healthcare toll-free at 1 (888) 560-5716. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina Healthcare's Customer Support Center.

Disability Access Grievances

If You believe Molina Healthcare or its doctors have failed to respond to Your disability access needs, You may file a grievance with Molina Healthcare.

BENEFITS AND COVERAGE

Molina Healthcare covers the services described in the section titled "What is Covered Under My Plan?", below, subject to the exclusions, limitations, and reductions set forth in this Agreement, only if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services
- The Covered Services are Medically Necessary
- The services are listed as Covered Services in this Agreement
- You receive the Covered Services from Participating Providers inside our Service Area for this product offered through the Marketplace, except where specifically noted to the contrary in this Agreement – e.g., in the case of an Emergency or need for out-of-area Urgent Care Services.

The only services Molina Healthcare covers under this Agreement are those described in this Agreement, subject to any exclusions, limitations, and reductions described in this Agreement.

COST SHARING (MONEY YOU WILL HAVE TO PAY TO GET COVERED SERVICES)

Cost Sharing is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide at the beginning of this Agreement.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act) that are provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide at the beginning of this Agreement. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by the Marketplace's rules.

YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF FLORIDA, INC. BENEFITS AND COVERAGE GUIDE CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

The Annual Out-of-Pocket Maximum is the total amount of Cost Sharing You may have to pay for Covered Services in a calendar year. The Annual Out-of-Pocket Maximum is specified in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. The Annual Out-of-Pocket Maximum includes payments You have made towards the Deductible, Copayments, and Coinsurance.

There may be an Annual Out-of-Pocket Maximum listed for the Member and an Annual Out-of-Pocket Maximum for a Family. If You are a Member in a Family of two or more Members, You will reach the Annual Out-of-Pocket Maximum either (i) when You meet the Annual Out-of-Pocket Maximum for the Member or (ii) when Your Family reaches the Out-of-Pocket Maximum for the Family. For example, if You reach the Annual Out-of-Pocket Maximum for the Member, You will not pay any more Cost Sharing for the calendar year, but every other Member in Your

Family must continue to pay Cost Sharing for the calendar Year until Your Family reached the Annual Out-of-Pocket Maximum for the Family.

Coinsurance

Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Co-insurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

Copayment

A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

Deductible

The Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Please refer to the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible. When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing, unless specifically stated or until You pay the Annual Out-of-Pocket Maximum. Please refer to the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide at the beginning of this Agreement to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

You are responsible for the Cost Sharing in effect on the date You receive Covered Services, except as follows:

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this Agreement, You pay the Cost Sharing in effect on Your admission date until You are discharged if the services are covered under Your prior health plan certificate of coverage and there has been no break in coverage. However, if the services are not covered under Your prior health plan certificate of coverage, or if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.

- For items ordered in advance, You pay the Cost Sharing in effect on the order date (although Molina Healthcare will not cover the item unless You still have coverage for it on the date You receive it) and You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Receiving a Bill

In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the Covered Services You receive, and the Participating Provider will bill You for any additional Cost Sharing amounts that are due. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing Amounts that are due under this Agreement. However, You are responsible for paying charges for any health care services or treatment which are not Covered Services under this Agreement.

How Your Coverage Satisfies the Affordable Care Act

Your Covered Services include Essential Health Benefits as determined by the Affordable Care Act. If non-EHB coverage is included in Your product, those Covered Services will be set out in this Agreement as well.

Your Essential Health Benefits coverage includes at least the 10 categories of benefits identified in the definition. You cannot be excluded from coverage in any of the 10 EHB categories except You will not be eligible for pediatric services (including pediatric dental separately purchased through the Marketplace and vision) that are Covered Services under this Agreement if You are 19 years of age or older.

The Affordable Care Act provides certain rules for Essential Health Benefits that will apply to how Molina administers Your product under this Agreement. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this Agreement. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In addition, Molina must ensure that the Cost Sharing which You pay for all Essential Health Benefits does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs which a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable

For qualifying Subscribers, there may be assistance to help make the product that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Marketplace to determine if You are eligible for tax credits to reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. The Marketplace also will have information about any annual limits on Cost Sharing towards Your Essential Health Benefits. The Marketplace can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina Healthcare will work with the Marketplace in helping You.

Molina Healthcare does not determine or provide Affordable Care Act tax credits.

Emergency Services Rendered by a Non-Participating Provider

Emergency Services that are obtained for treatment of an Emergency Medical Condition, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Benefits and Coverage Guide. When services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina will calculate the allowed amount that will be covered under this benefit, in accordance with applicable federal and state laws. You may be responsible for charges that exceed the allowed amount covered under this benefit.

Services of specified non-contracted hospital based physician

In the event You receive care from a hospital based Non-Participating Provider who is delivering services in a Participating Provider hospital, including, but not limited to, pathologists, radiologists, and anesthesiologists, Molina shall pay for Medically Necessary and Prior Authorized physician care rendered to You so long as the services are covered under this Agreement. The amount that Molina will pay for services under this provision is equal to 100% of the Medicare Resource Based Relative Value Scale and that amount is subject to the applicable Coinsurance for inpatient and/or outpatient professional services described in Your Benefits and Coverage Guide.

WHAT IS COVERED UNDER MY PLAN?

This section tells You what medical services Molina Healthcare covers, also known as Your Benefits and Coverage or Covered Services.

In order for a service to be covered, **it must be Medically Necessary**.

You have the right to appeal if a service is denied. Turn to page 70 for information on how You can have Your case reviewed (see Complaints and Appeals).

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Go to page 46 for information. Molina Healthcare also may cover routine medical costs for Members in Approved Clinical Trials. Go to page 46 to find out more.

Covered Services may be provided by Other Practitioners contracted with Molina Healthcare within the scope of their license. Other Practitioners may include a range of healthcare professionals, including without limitation physicians, dentists, nurses, midwives, nurse midwives, certified registered nurse anesthetists, advanced registered nurse practitioners, audiologists, podiatrists, osteopaths, chiropractors, ophthalmologists, physician assistants, clinical psychologists, social workers, mental health counselors, pharmacists, nutritionists, physical therapists, speech therapists and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under the authority of a physician or legally constituted professional association, or other authority consistent with the laws of the State of Florida.

Certain medical services described in this section will only be covered by Molina Healthcare if You obtain Prior Authorization *before* seeking treatment for such services. For a further explanation of Prior Authorization and a complete list of Covered Services which require Prior Authorization, go to pages 23 – 25. However, Prior Authorization will never apply to treatment of Emergency Conditions or for Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

PREVENTIVE CARE AND SERVICES

Preventive Services and the Affordable Care Act

Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services, without Your paying any Cost Sharing:

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

- Those immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;

- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive care must be furnished by a Participating Provider to be covered under this Agreement.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement for product years which begin one year after the date the recommendation or guideline is issued or on such other date as required by the Affordable Care Act. The product year, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care as long as they are consistent with the Affordable Care Act and applicable Florida law. These coverage limitations also are applicable to the preventive care benefits listed below.

To help You understand and access Your benefits, preventive services for adults and children which are covered under this Agreement are listed below

Preventive Care for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents (through age 18), without Your paying any Cost Sharing if furnished by a Participating Provider:

- Complete health history
- Physical exam including growth assessment
- Nutritional health assessment
- Vision screening
- Dental screening (1 visit limit per six month period)
- Speech and hearing screening
- Immunizations*
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections
- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health education
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of the exam
- Lead blood level testing. Parents or legal guardians of Members ages six months to 72 months are entitled to receive from their PCP; oral or written anticipatory guidance on lead exposure, This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.
- All comprehensive perinatal services are covered. This includes: perinatal and postpartum care, health education, nutrition assessment and psychological services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21, including those with special health care needs.
- Depression screening: adolescents
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a Participating Provider
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns

*If You take Your child to Your local health department or the school has given Your child any shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

Preventive Care for Adults and Seniors

The following outpatient preventive care services are covered and recommended for all adults, including seniors, without Your paying any Cost Sharing if furnished by a Participating Provider:

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Mammogram for women (based on Your age)
- Pap smear for women (based on Your age) and health status including human papilloma virus (HPV) screening test
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Osteoporosis screening for high risk individuals
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health education
- Family planning services
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing exams and screenings
- Preventive vision screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA screening, counseling about breast cancer preventive medication
- Chlamydial infection screening: women
- Depression screening: adults
- Healthy diet counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Tobacco use counseling and interventions
- Well-woman visits
- Screening and counseling for interpersonal and domestic violence: women

Mammogram screenings will be provided to a Member no less often than:

- a baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
- a mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.
- a mammogram every year for any woman who is 50 years of age or older.
- one or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

SERVICES OF PHYSICIANS AND OTHER PRACTITIONERS

We cover the following outpatient services when furnished by a physician or appropriate Other Practitioner when practicing within the scope of his or her license:

- Prevention, diagnosis, and treatment of illness or injury
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Physician care in or out of the hospital
- Consultations and well-child care
- If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) for routine examinations and prenatal care
- Mastectomy postsurgical care, as deemed medically necessary, in accordance with prevailing medical standards and after consultation between You and the treating physician.
- Complications of pregnancy, including postpartum care of the female Member
- Primary Care Doctor, Specialist Physician and other Practitioner administered drugs (e.g., medical self-administered drugs in the treatment of cancer, diabetes or conditions requiring immediate stabilization or administration of dialysis services related to diabetes. Copayments for dialysis services are listed in the Benefits and Coverage Guide.)
- Treatment of osteoporosis for Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, 1) estrogen-deficient individuals who are at clinical risk for osteoporosis, 2) individuals who have vertebral abnormalities, 3) individuals who are receiving long-term glucocorticoid (steroid) therapy, 4) individuals who have primary hyperparathyroidism, and 5) individuals who have a family history of osteoporosis.
- Child health supervision services for Dependent children from birth to 16 years of age (e.g., physician-delivered or physician-supervised services that include, at a minimum, services delivered at the intervals and scope required by law. Child health supervision services must include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be limited to those that are required by the prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Visits are limited to one visit payable to one Participating Provider for all of the services provided at each visit.

Cleft Lip and Cleft Palate

We cover Medically Necessary treatment of cleft lip and cleft palate for Dependent children under the age of 18. Covered Services include medical, speech therapy, audiology, and nutrition services if such services are prescribed by the child's PCP or treating Participating Provider physician to whom the child has been Referred and the PCP or treating Participating Provider physician certifies that such services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate. Copayments for outpatient professional services listed in the Benefits and Coverage Guide apply to services for cleft lip and cleft palate.

Dermatological Services

We cover Medically Necessary dermatological services for office visits and minor procedures and tests provided by a dermatologist who is a Participating Provider. Dermatological services are limited to five office visits per calendar year without an authorization or referral from Your PCP. Copayments for outpatient professional services listed in the Benefits and Coverage Guide apply to dermatological services.

HABILITATIVE SERVICES

We cover Medically Necessary habilitative services. Habilitative services are defined as health care services and devices that are designed to assist individuals acquiring, retaining or improving self-help, socialization, and adaptive skills and functioning necessary for performing routine activities of daily life successfully in their home and community based settings. These services may include physical therapy, occupational therapy, speech therapy, personal attendant services and durable medical equipment.

REHABILITATIVE SERVICES

We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy and occupational therapy in a setting appropriate for the level of disability or injury. For outpatient therapies the following combined limits apply:

- Cardiac Rehabilitation Therapy (35 combined visit limit for all outpatient therapies per calendar year)
- Occupational Therapy (35 combined visit limit for all outpatient therapies per calendar year)
- Physical Therapy (35 combined visit limit for all outpatient therapies per calendar year)
- Speech Therapy (35 combined visit limit for all outpatient therapies per calendar year)
- Massage Therapy (35 combined visit limit for all outpatient therapies per calendar year)
- Spinal Manipulative Therapy (26 visit limit per calendar year is combined with the 35 combined visit limit for other outpatient therapies list above)

OUTPATIENT MENTAL/BEHAVIORAL HEALTH SERVICES

We cover the following outpatient care when provided by Participating Providers who are physicians or other licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient services for the purpose of monitoring drug therapy

We cover outpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for mental or behavioral conditions that the DSM identifies as something other than a "mental disorder."

"Mental Disorders" include the following conditions:

Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa

OUTPATIENT SUBSTANCE ABUSE DISORDER SERVICES

We cover the following outpatient care for treatment of substance abuse disorders:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group substance abuse counseling
- Medical treatment for withdrawal symptoms
- Individual substance abuse evaluation and treatment
- Group substance abuse treatment

We do not cover outpatient services for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Substance Abuse Disorder Services" section.

DIABETES MANAGEMENT SERVICES

We cover Medically Necessary and appropriate outpatient self-management training and educational services, nutritional counseling , equipment and supplies used to treat diabetes if the treating Primary Care Doctor or other Participating Provider physician who specializes in the treatment of diabetes certifies that such services are Medically Necessary. Covered Services also may include routine foot care (e.g., trimming of toenails, corns, calluses and therapeutic shoes, including inserts and/or modifications) for the treatment of diabetic foot disease. Copayments for outpatient professional services listed in the Benefits and Coverage Guide apply to services for diabetes management services.

To be covered under this product, diabetes self-management training and education services must be provided under the direct supervision of a certified diabetes educator or a board certified Participating Provider physician specializing in endocrinology. Nutritional counseling must be provided by a licensed Participating Provider dietician to be covered.

DENTAL AND ORTHODONTIC SERVICES

We do not cover most dental and orthodontic services, but we do cover some dental and orthodontic services as described in this "Dental and Orthodontic Services" section for all Members.

Dental Services for Radiation Treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck if a Participating Provider physician provides the services or if Molina Healthcare authorizes a Referral to a dentist.

Dental Anesthesia

For necessary dental procedures, we cover general anesthesia and the Participating Provider facility's services associated with the anesthesia for:

- A Member under age eight whose treating Participating Provider, in consultation with the dentist, determines the child has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

- A Member who has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition.

We do not cover dental implants.

Dental Services Related to Accidental Injury

We cover services for dental work that are to repair of sound natural teeth for an injury that is caused by a sudden, unintentional, and unexpected event or force within 62 days of the injury.

Dental and Orthodontic Services for Cleft Palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services, if they meet all of the following requirements:

- The Member is under 18;
- The services are an integral part of a reconstructive surgery for cleft palate; and
- A Participating Provider provides the services or Molina Healthcare authorizes a Referral to a Non-Participating Provider who is a dentist or orthodontist.

Services to Treat Temporomandibular Joint Syndrome ("TMJ")

We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ")

- Medically Necessary medical non-surgical treatment (e.g., splint and physical therapy) of TMJ;
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed.

For Covered Services related to dental or orthodontic care in the above sections, You will pay the

Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, see "Inpatient Hospital Services" in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide for the Cost Sharing that applies for hospital inpatient care.

We cover two TMJ procedures per year and one splint per six-month period, unless addition splints are determined to be Medically Necessary.

Molina Healthcare does not cover any other services related to dental procedures, such as the dentist's services, except as provided in this "Dental and Orthodontic Services" section.

PEDIATRIC VISION SERVICES

We cover the following vision services for Members under the age of 19:

- One routine vision screening and eye exam every calendar year.
- Prescription eye glasses: frames and lenses, limited to one pair of prescription eye glasses once every 12 months, and including polycarbonate lenses and scratch resistant coating.
- Contact Lenses: limited to once every 12 months, in lieu of prescription glasses; includes evaluation, fitting and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.
- Low vision optical devices including low vision services, and training and instruction to maximize remaining usable vision, with follow-up care, when services are Medically Necessary and Prior Authorized. When Prior Authorized, coverage includes one comprehensive low vision evaluation every five years, high-power spectacles, magnifiers and telescopes as Medically Necessary; and follow-up care – four visits in any five-year period.

Laser corrective surgery is not covered.

FAMILY PLANNING

We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. You can do this without having to get permission from Molina Healthcare. (Molina Healthcare pays the doctor or clinic for the family planning services You get.) Family planning services include:

- Health education and counseling to help You make informed choices and to understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use.
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera.
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers.
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency.

- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Pregnancy testing and counseling.
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated.
- Screening, testing and counseling of at-risk individuals for HIV, and Referral for treatment.

PREGNANCY TERMINATIONS

Molina Healthcare covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by any applicable laws in the State of Florida.

Pregnancy termination services are office-based procedures and do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or ambulatory surgical center Prior Authorization is required.

Office Visit and Outpatient Surgery Cost Sharing will apply.

Keep in mind that some hospitals and providers may not provide pregnancy termination services.

ENTERAL FORMULAS

We cover prescription and non-prescription enteral formulas for home use when prescribed by a Participating Provider physician as Medically Necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period are covered.

(Prescription drug Cost Sharing will apply)

OUTPATIENT HOSPITAL/FACILITY SERVICES

OUTPATIENT SURGERY

We cover outpatient surgery services provided by Participating Providers if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for Professional services and Facility services.

Outpatient surgery services provided by Participating Providers also include coverage for soft lenses or sclera shells, for the treatment of aphakic patients, initial glasses or contact lenses following cataract surgery and physician services to treat an injury to or disease of the eye

OUTPATIENT PROCEDURES (OTHER THAN SURGERY)

We cover outpatient procedures other than surgery provided by Participating Providers if a licensed staff member monitors Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Separate Cost Sharing may apply for Professional services and Facility services.

Molina Healthcare covers chemotherapy drugs and related services when prescribed and administered by Participating Providers. The prescription drug cost share will apply to the chemotherapy drugs.

SPECIALIZED SCANNING SERVICES

We cover specialized scanning services to include CT Scan, PET Scan and MRI by Participating Providers. Separate Cost Sharing may apply for Professional services and Facility services.

RADIOLOGY SERVICES

We cover x-rays and radiology services, other than specialized scanning services, when furnished by Participating Providers.

LABORATORY TESTS

We cover the following services when furnished by Participating Providers and Medically Necessary, and subject to Cost Sharing:

- Laboratory tests
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood and blood plasma
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high risk pregnancy

MENTAL/BEHAVIORAL HEALTH
OUTPATIENT INTENSIVE PSYCHIATRIC TREATMENT PROGRAMS

We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency or out-of-area Urgent Care Services, Your hospital stay will be covered. This happens even if You do not have a Prior Authorization.

MEDICAL/SURGICAL SERVICES

We cover the following inpatient services in a Participating Provider hospital, when the services are generally and customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialists, surgeons and, when necessary surgical assistants
- Anesthesia
- Drugs prescribed in accord with our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections, including inpatient care that is medically necessary in accordance with prevailing medical standards and after consultation between You and the treating physician.
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning
- Chemotherapy; (The prescription drug cost share will apply to the chemotherapy drugs)

MATERNITY CARE

We cover the following maternity care services related to labor and delivery:

- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). However, a longer inpatient stay for You and Your newborn will be authorized if determined Medically Necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards.

- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina Healthcare will cover post discharge services and laboratory services. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).

- Services provided by licensed birthing centers and by certified nurse-midwives and licensed midwives working within the scope of their licenses.

- Medically Necessary inpatient services associated with maternity care

MENTAL/BEHAVIORAL HEALTH
INPATIENT PSYCHIATRIC HOSPITALIZATION

We cover inpatient psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians and other Participating Providers who are licensed health care professionals acting within the scope of their license.

We cover inpatient hospital mental or behavioral health services only when the Member has a "**Mental Disorder**." A "**Mental Disorder**" is a mental health condition identified as a "mental disorder" in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for mental or behavioral conditions that the DSM identifies as something other than a "mental disorder."

"**Mental Disorders**" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, or bulimia nervosa.

SUBSTANCE ABUSE DISORDER
INPATIENT DETOXIFICATION

We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of its withdrawal symptoms, including room and board, Participating Provider physician services, drugs, dependency recovery services, education, and counseling.

SUBSTANCE ABUSE DISORDER
TRANSITIONAL RESIDENTIAL RECOVERY SERVICES

We cover substance abuse disorder treatment in a nonmedical transitional residential recovery setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment.

SKILLED NURSING FACILITY

We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and board
- Physician and nursing services
- Medications
- Intravenous solutions
- Transfusion supplies and equipment
- Chemotherapy treatment for proven malignant disease (The prescription drug cost share will apply to the chemotherapy drugs)
- Physical, speech and occupational therapies

You must have a Prior Authorization for these services before the service begins. You will continue to get care without interruption.

The SNF benefit is limited to 60 days per calendar year.

HOSPICE CARE

If You are terminally ill, we cover these hospice services:

- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services
- Physician services
- Drugs
- Medical supplies and appliances
- Respite care for up to seven days per occurrence. Respite is short-term inpatient care provided in order to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management
- Physical therapy, occupational therapy, and speech-language therapy, when provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for people who are diagnosed with a terminal illness (life expectancy of twelve (12) months or less). They can choose hospice care instead of the traditional services covered by this product. Please contact Molina Healthcare for further information. You must receive Prior Authorization for all inpatient hospice care services.

APPROVED CLINICAL TRIALS

We cover routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled in this product
- Be diagnosed with cancer or other life threatening disease or condition
- Be accepted into an approved clinical trial (as defined below)
- Be referred by a Molina Healthcare doctor who is a Participating Provider
- Received Prior Authorization or approval from Molina Healthcare. Such Prior Authorization or approval will be consistent with the standards in the Affordable Care Act.

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and (1) the study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit or place conditions on its coverage of Your routine patient costs associated

with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this Agreement based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under “Inpatient Hospital Services” in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide.

Molina does not have an obligation to cover certain items and services which are not routine patient costs, as determined by the Affordable Care Act, even when You incur these costs while in an approved clinical trial. Costs excluded from coverage under Your product include:

- The investigational item, device or service itself
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- Any service inconsistent with the established standard of care for the patient’s diagnosis

All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. Contact Molina Healthcare or Your PCP for further information.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under “Inpatient Hospital Services” in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide.

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Participating Provider physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, Molina Healthcare covers reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services are not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under “Inpatient Hospital Services” in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide.

RECONSTRUCTIVE SURGERY EXCLUSIONS

The following reconstructive surgery services are **not** covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

TRANSPLANT SERVICES

We cover transplants of the following organs and tissue at participating transplant facilities if a Participating Provider physician provides a written Referral for care to a transplant facility and Molina Healthcare authorizes the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

1. Cornea

2. Heart

3. Lung

4. Liver

5. Kidney

6. Pancreas

7. Bone Marrow Transplants when the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty and not Experimental or Investigational. As used in this EOC, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or lifeprolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

8. Other transplants as approved by Molina in its sole discretion consistent with nationally established guidelines.

After the Referral to a transplant facility, the following applies:

- If either the physician or the referral facility determines that You do not satisfy its respective criteria for a transplant, Molina Healthcare will only cover services You receive before that determination is made
- Molina Healthcare is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for services for living transplant donors, Molina Healthcare provides certain donation-related services for a donor, or an individual identified as a

potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling our Customer Support Center toll-free at 1 (888)-560-5716.

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services are not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide.

Molina Healthcare provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor services at no charge.

We do not cover the following transplants or transplant-related services:

- Experimental or Investigational transplants
- Transplants involving non-human organs or tissue
- Donations or acquisitions of organs or tissue from a recipient not covered under this product
- Transplants involving sold or donated organs
- Bone marrow transplants not specifically listed in Rule 59B-12.001 of the Florida Administrative Code
- Services in connection with the identification of a donor from local, state or national listings except for bone marrow transplants
- Non-medical costs
- Devices that replace either the atrium or the ventricle

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Healthcare Drug Formulary or has been approved by Molina Healthcare's Pharmacy Department
- They are ordered or given while You are in an emergency room or hospital
- They are given while You are in a rest home, nursing home, or convalescent hospital and the they are ordered by a Participating Provider for a Covered Service and You got the drug or medication through a pharmacy that is in the Molina Healthcare pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

We cover preferred brand name drugs, non-preferred brand name drugs, generic drugs and specialty (oral and injectable) drugs when such prescription drugs are on the Drug Formulary and obtained through Molina Healthcare's contracted pharmacies within Florida. Non-Drug Formulary Drugs may be covered only as provided in the "Access to Drugs Which Are Not Covered" section below.

Prescription drugs are covered outside of the state of Florida (out of area) for Emergency or Urgent Care services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina Healthcare's Customer Support Center toll-free at 1 (888)-560-5716 for assistance. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 955-8771 or contact us with the National Relay Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888)-560-5716. You may view a list of pharmacies on Molina Healthcare's website, www.molinahealthcare.com.

Molina Healthcare Drug Formulary (List of Drugs)
Molina Healthcare has a list of drugs that it will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. The group meets every three months to talk about the drugs that are in the formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added or taken off the Drug Formulary based on changes in medical practice, medical technology, and when new drugs come on the market.

You can look at our Drug Formulary on our Molina Healthcare website at www.molinahealthcare.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888)-560-5716, Monday through Friday, 8:00 a.m. through 7:00 p.m. ET. If You are deaf or hard of hearing, call toll-free 1 (800) 955-8771 or dial 711 for the National Relay Service. You can also ask us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Access to Drugs Which Are Not Covered
Molina does have a process to allow You to request and gain access to clinically appropriate drugs that are not covered under Your product. If Your doctor orders a drug that is not listed in the Drug Formulary that he or she feels is best for You, Your doctor may make a request that Molina cover the drug for You through Molina Healthcare's Pharmacy Department. If the request is approved, Molina Healthcare will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor stating why the drug was denied.

If You are taking a drug that is no longer on our Drug Formulary, Your doctor can ask us to keep covering it by sending us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You. Molina Healthcare will cover specific non-Drug Formulary drugs when the prescriber documents in the Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or that the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, not subject to Cost Sharing.

Generic Drugs

Generic drugs have the same ingredients as brand name drugs. To be FDA (government) approved the generic drug must have the same active ingredient, strength and dosage (formulation) as the brand name drug. Companies making a generic drug have to prove to the FDA that the drug works just as well and is as safe as the brand name drug.

If Your doctor orders a brand name drug and there is a generic available, we will cover the generic medication.

If Your doctor says that You must have the brand name drug instead of the generic, he/she must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

Brand Name Drugs
Brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by its manufacturer and are advertised and sold under that name and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and our pharmacy benefit manager.

Specialty Oral and Injectable Drugs
Specialty drugs are prescription legend drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies.

Molina Healthcare may require that specialty drugs be obtained from a participating specialty pharmacy or facility for coverage. Molina Healthcare's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office.

Stop-Smoking Drugs
We cover drugs to help You stop smoking. You must also enroll in and complete a certified stop-smoking program to get them. You can learn more about Your choices by calling Molina Healthcare's Health Education Department toll-free at 1 (866) 472-9483, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication.

Diabetic Supplies
Diabetic supplies, such as insulin syringes, glucometers, blood glucose test strips and urine test strips are covered supplies.

Day Supply Limit
The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorized.

Cancer Treatment – Off-Label Drugs

Molina Healthcare will cover drugs prescribed for the treatment of cancer so long as the drug is recognized for treatment of the diagnosed cancer in a standard reference compendium or recommended in the medical literature. The cost share for off label drugs will vary depending upon how the drug is administered. For example, the Prescription Drug Coverage cost share listed in the Benefit and Coverage Guide applies for outpatient administration of off label drugs and is subject to Prior Authorization for any drugs that are not listed on the Molina Healthcare formulary. Drugs administered in an inpatient are subject to the inpatient cost share listed in the Benefit and Coverage Guide.

Molina also will cover the Medically Necessary services associated with administration of the drug.

Molina will not exclude or deny coverage of a drug which has been so recognized in a standard reference compendium or recommended in the medical literature only because it has not been approved by the United States Food and Drug Administration for the particular indication.

For the purposes of this "Cancer Drugs and Treatment" section, the term "**medical literature**" means scientific studies published in a United States peer-reviewed national professional journal. And, the term "s**tandard reference compendium**" means authoritative compendia identified by the Secretary of the United States Department of Health and Human Services and recognized by the United States Centers for Medicare and Medicaid Services.

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT

If You need Durable Medical Equipment, Molina Healthcare will rent or purchase the equipment for You. Prior Authorization (approval) from Molina Healthcare is required for Durable Medical Equipment. The equipment must be provided through a vendor that is contracted with Molina Healthcare. We cover reasonable repairs, maintenance, delivery and related supplies for Durable Medical Equipment. You may be responsible for repairs to Durable Medical Equipment if they are due to misuse or loss.

Covered Durable Medical Equipment includes (but is not limited to):

- Oxygen and oxygen equipment
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy bags, urinary catheters and supplies.

In addition, we cover the following Durable Medical Equipment and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors and blood glucose testing strips
- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices

- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes related foot problems
- Insulin syringes
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

We do not cover Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment; electric scooters, hearing aids, air conditions and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used.

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets Your medical needs
- You receive the device from the provider or vendor that Molina Healthcare selects

When we do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If we cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by us.

For internally implanted devices, Inpatient Hospital Services Cost Sharing or Outpatient Hospital/Facility Services Cost Sharing will apply, as applicable.

External devices

We cover the following external prosthetic and orthotic devices:
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist

- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

For external devices, Durable Medical Equipment Cost Sharing will apply.

HOME HEALTHCARE

We cover these home health care services when Medically Necessary, referred by Your PCP, and approved by Molina Healthcare:

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Physical therapy, occupational therapy, or speech therapy
- Medical social services
- Home health aide services
- Medical supplies
- Necessary medical appliances

Home health services are limited to medical social services, nutritional guidance, respiratory or inhalation therapy, physical, speech or occupational therapy by a physical, occupational or speech therapist and home health aide and services. Home health services must be consistent with a plan of treatment ordered under the supervision of a registered nurse.

The following home health care services are covered under Your product:

- Up to two hours per visit for nursing care by a registered nurse, licensed practical nurse, medical social worker, physician, occupational or speech therapist
- Up to four hours per visit by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 40 hours per calendar year (counting all home health visits)

Home health services are limited to 20 visits per calendar year. You must have approval for all home health services before the service begins.

Please refer to the "Exclusions" section of this Agreement for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation
We cover Emergency transportation (ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary.

Non-Emergency Medical Transportation
We cover non-Emergency medical transportation to medical facilities when Your medical and physical condition does not allow You to take regular means of public or private transportation (car, bus, air, etc.). This requires that You also have a written prescription from Your doctor.

Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. You must have Prior Authorization from Molina Healthcare for these services before the services are given. Please review the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product. Please review the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product.

Non-Emergency Non-Medical Transportation
Non-Emergency non-medical transportation is available if You are recovering from serious injury or medical procedure that prevents You from driving to a medical appointment. You must have no other form of transportation available. Your physician (PCP or Specialist Physician) confirms that You require non-Emergency non-medical transportation to and from an appointment on a specified date.

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Call at least two to three working days before Your appointment to arrange this transportation.

If You need non-Emergency non-medical transportation, please call Your PCP or Molina Healthcare's Customer Support Center to see if You qualify for these services. You must have Prior Authorization to get these services before the services are given. Please review the Molina Healthcare of Florida, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product.

HEARING SERVICES

We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section).

We do cover the following:

- Routine hearing screenings that are Preventive Care Services: no charge

OTHER SERVICES

DIALYSIS SERVICES

We cover acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside our Service Area
- You satisfy all medical criteria developed by Molina Healthcare.
- A Participating Provider physician provides a written Referral for care at the facility
- The dialysis services relate to the treatment of diabetes

Copayments for dialysis services are listed in the Benefits and Coverage Guide.

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA (INCLUDING THE UNITED STATES)

Your Covered Services include Urgent Care Services and Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States. If You need Urgent Care Services while traveling outside the United States, go to your nearest urgent care center or emergency room. If You require Emergency Services while traveling outside the United States, please use that country's or territory's emergency telephone number or go to the nearest emergency room.

If You receive health care services while traveling outside the United States, You will be required to pay the Non-Participating Provider's charges at the time You obtain those services. You may submit a claim for reimbursement to Molina Healthcare for charges that you paid for Covered Services furnished to You by the Non-Participating Provider. Members are responsible for ensuring that claims and/or records of such services are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment/service may also be required for proper reimbursement from Molina.
Your claims for reimbursement for Covered Services should be submitted as follows:

Molina Healthcare of Florida, Inc.
P.O. Box 22812
Long Beach, California 90801

Claims for reimbursement for Covered Services while You are traveling outside the United States must be verified by Molina Healthcare before payment can be made. Molina will calculate the allowed amount that will be covered for Urgent Care Services and Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws. Because these services are performed by a Non-Participating Provider You will only be reimbursed for the allowed amount, which may be less than the amount you were charged by the Non-Participating Provider. You will not be entitled to reimbursement for charges for health care services or treatment that are excluded from coverage under this Agreement, specifically those identified in "Services Provided Outside the United States (or Service Area)" in the "Exclusions" section of this Agreement.

EXCLUSIONS

What is Excluded from Coverage Under My Plan?

This "Exclusions" section lists items and services excluded from coverage under this Agreement. These exclusions apply to all services that would otherwise be covered under this Agreement regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Artificial Insemination and Conception by Artificial Means

Infertility treatment and services are not covered. The exclusions include all services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Certain Exams and Services

Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

Certain Mental Health Exams and Services

Mental health exams and services involving : 1) services for psychological testing associated with the evaluation and diagnosis of learning disabilities; 2) marriage counseling; 3) pre-marital counseling; 4) court-ordered care or testing, or required as a condition of parole or probation; 5) testing of aptitude, ability, intelligence or interest; 6) evaluation for the purpose of maintaining employment inpatient confinement or inpatient mental health services received in a residential treatment facility

Cosmetic Services

Services that are intended primarily to change or maintain Your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial Care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

Dental and Orthodontic Services

Dental and orthodontic services such as x-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to services covered under "Dental and Orthodontic Services" in the "What is Covered Under My Plan?" section.

Disposable Supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies that are listed as covered in the "What is Covered Under My Plan?" section.

Durable Medical Equipment

We do not cover Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment; electric scooters, hearing aids, air conditions and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used.

Experimental or Investigational Services

Any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

This exclusion does not apply to any of the following:

- Services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan?" section

Please refer to the "Complaints and Appeals" section for information about appeals related to denied requests for Experimental or Investigational services.

Hair Loss or Growth Treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate Care

Care in a licensed intermediate care facility. This exclusion does not apply to services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "What is Covered Under My Plan?" section.

Infertility Services

Services related to the diagnosis and treatment of infertility.

Items and Services That are Not Health Care Items and Services

Molina Healthcare does not cover services that are not health care services, for example:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching You how to read, whether or not You have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Items and Services to Correct Refractive Defects of the Eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except for the following Covered Services:

- Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section
- Soft lenses or sclera shells for the treatment of aphakic patients
- Initial glasses or contact lenses following cataract surgery
- Physician services to treat an injury to or disease of the eye

Massage Therapy
Massage therapy is not covered except as specifically provided in the "Rehabilitative Services" in "What is Covered Under My Plan?" section.

Oral Nutrition

Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed in accordance with the “Enteral Formulas” section of this Agreement.

Residential Care

Care in a facility where You stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the “Hospice Care” section, a licensed facility providing crisis residential services covered under “Inpatient psychiatric hospitalization and intensive psychiatric treatment programs” in the “Mental/Behavioral Health Services” section, or a licensed facility providing transitional residential recovery services covered under the “Substance Abuse Disorder Services” section.

Routine Foot Care Items and Services

Routine foot care items and services that are not Medically Necessary except as described Diabetes Management Services section above.

Services Not Approved by the Federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

These exclusions do not apply to:

- Services covered under “Approved Clinical Trials” in the “What is Covered Under My Plan” section
- Services covered under “Cancer Drugs and Treatment” provisions in the “Prescription Drug Coverage” subsection in “What is Covered under My Plan”

Please refer to the “Independent Medical Review for Denials of Experimental/Investigational Therapies” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People

Except as otherwise provided in this Agreement, services that are performed by people who do not require licenses or certificates by the state to provide health care services are not covered.

Services Related to a Non-Covered Service

When a Service is not covered, all services related to the non-Covered Service are excluded, except for services Molina Healthcare would otherwise cover to treat complications of the non-Covered Service. For example, if You have a non-covered cosmetic surgery, Molina Healthcare would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina Healthcare would cover any services that Molina Healthcare would otherwise

cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement is not covered, except for otherwise-Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Transgender Surgery

Transgender surgery is not covered.

Bariatric Surgery and Weight Control Services

We do not cover bariatric surgeries or any other weight loss surgical procedure. We do not cover any service to lose, gain or maintain weight, regardless of the reason for the service or whether the service is part of a treatment plan for a medical condition.

Cosmetic Services

Services or surgeries that are intended primarily to change or maintain Your appearance are not covered, except that this exclusion does not apply to any of the following:

- Services covered under “Reconstructive Surgery” in the “What is Covered Under My Plan?” section, and
- Services covered under “Prosthetic and Orthotic Devices” in the “What is Covered Under My Plan?” section

Travel and Lodging Expenses

Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina’s travel and lodging guidelines. Molina Healthcare’s travel and lodging guidelines are available from our Customer Support Center by calling toll free at 1(888) 560-5716 or call our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 955-8771 or dial 711 for the National Relay Service.

Services Provided Outside the United States (or Service Area)

Any services and supplies provided to a Member outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialist care and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area unless they are Urgent Care Services or Emergency Services furnished to a Member while traveling.
When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered.

THIRD-PARTY LIABILITY

You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that You are made whole for all other damages resulting from the wrongful act or omission before Molina Healthcare is entitled to reimbursement, then You shall:

- Reimburse Molina Healthcare for the reasonable cost of services paid by Molina Healthcare to the extent permitted by the laws of the State of Florida immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Molina Healthcare's effectuation of its lien rights for the reasonable value of services provided by Molina Healthcare to the extent permitted under the laws of the State of Florida, Inc. Molina Healthcare's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

Molina Healthcare shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting the rights of Molina Healthcare including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina Healthcare shall not furnish benefits under this Agreement which duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina Healthcare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the Workers' Compensation carrier, as to Your ability to collect under workers' compensation laws, Molina Healthcare will provide the benefits described in this Agreement until resolution of the dispute.

If Molina Healthcare provides benefits which duplicate the benefits You are entitled to under workers' compensation law, Molina Healthcare shall be entitled to reimbursement for the reasonable cost of such benefits.

RENEWAL AND TERMINATION

How Does my Molina Healthcare Coverage Renew?
Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Renewal is subject to Molina Healthcare's right to amend this Agreement. You must follow the procedures required by the Marketplace to redetermine Your eligibility for enrollment every year during the Marketplace's annual open enrollment period.

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum

amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina Healthcare.

When Will My Molina Healthcare Membership End?
(Termination of Benefits and Coverage)
The termination date of Your coverage is the first day You are not covered with Molina Healthcare (for example, if Your termination date is July 1, 2014, Your last minute of coverage was at 11:59 p.m. on June 30, 2014). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina Healthcare, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina Healthcare will return to You within 30 days the amount of Premiums paid to Molina Healthcare which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Molina Healthcare.

Your membership with Molina Healthcare will terminate if You:

- **No Longer Meet Eligibility Requirements:** You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina Healthcare or the Marketplace. You no longer live or work in Molina Healthcare's Service Area for this product. The Marketplace will send You notice of any eligibility determination. Molina Healthcare will send You notice when it learns You have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

- **Request Disenrollment:** You decide to end Your membership and disenroll from Molina Healthcare by notifying Molina Healthcare and/or **the Marketplace**. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Molina Healthcare may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.

- **Change the Marketplace Health Plans**: You decide to change from Molina Healthcare to another health plan offered through the Marketplace either if You are not satisfied with Molina Healthcare or during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace's special enrollment procedures, or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina Healthcare. Some examples include:

  - Misrepresenting eligibility information.
  - Presenting an invalid prescription or physician order.
  - Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- **Time limit on Certain Defenses**: Relative to a misstatement, omissions, or inaccuracies in the application, after 2 years from the issue date, only fraudulent misstatements in the application may be used to terminate this Agreement or deny any claim for loss incurred or disability starting after the 2-year period.

- **Discontinuation:** If Molina Healthcare ceases to provide or arrange for the provision of health benefits for new or existing health care service plan contracts, in which case Molina Healthcare will provide You with written notice at least 180 days prior to discontinuation of those contracts.

- **Withdrawal of Product:** Molina Healthcare withdraws this product from the market, in which case Molina Healthcare will provide You with written notice at least 90 days before the termination date.

- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina Healthcare may terminate Your coverage as further described below.

Your coverage under certain Benefits and Coverage will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision Services covered under this Agreement and, as a result, such Member's coverage under those specific Benefits and Coverage will terminate on his or her 19th birthday, without affecting the remainder of this Agreement.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums. Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the first day of that month. This is the "**Due Date.**" Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Molina Healthcare does not receive the full Premium payment due on or before the Due Date, Molina Healthcare will send a notice of non-receipt of Premium payment and cancellation of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:

  - A statement that Molina Healthcare has not received full Premium payment and that we will terminate this Agreement for nonpayment if we do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
  - The amount of Premiums due.

- The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if we do not receive the required Premiums.

- Except for Subscribers who receive advance payment of the premium tax credit, if You have received a Late Notice that Your coverage is being cancelled or not renewed due to failure to pay Your Premium, Molina Healthcare will give You a 30-day "grace period." Subscribers who receive advance payment of the premium tax credit will be given a three month "grace period." During the grace period, You can avoid cancellation or nonrenewal by paying the Premium You owe to Molina Healthcare. If You do not pay the Premium by the end of the grace period, this Agreement will be cancelled at the end of the grace period. You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period.

- Molina Healthcare will pay for Covered Services received during the first 30-days of the grace period. For Subscribers entitled to the three month grace period, Molina will hold back payment for Covered Services after the first month of the grace period until we receive the delinquent Premiums. If Premiums are not received by the end of the three month grace period, the Subscriber will be responsible for payment of the Covered Services received during the second and third months.

Reinstatement after Termination for Nonpayment of Premiums

- When You have been terminated for nonpayment of Premiums, You may not enroll in Molina Healthcare even after paying all amounts owed unless we approve the enrollment.

- If Molina Healthcare terminates this Agreement for nonpayment of Premiums, we will permit reinstatement of this Agreement once during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice, described below. Molina Healthcare will not reinstate this Agreement if You do not obtain reinstatement of Your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than once in a 12-month period. In either case, You will be ineligible to re-enroll for a period of 12 months from the effective date of termination.

Termination Notice: Upon termination of this Agreement, Molina Healthcare will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended or will end. The Termination Notice will include the reason or reasons for the termination of Your Agreement.

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Healthcare Member?

These rights and responsibilities are posted on the Molina Healthcare web site: www.molinahealthcare.com.

Your Rights
You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare.

- Get information about Molina Healthcare, our providers, our doctors, our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina Healthcare's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).
- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina Healthcare or Your care. You can call, fax, e-mail or write to Molina Healthcare's Customer Support Center.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina Healthcare (leave the Molina Healthcare product).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina Healthcare to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get interpreter services on a 24 hour basis at no cost to help You talk with Your doctor or us if You prefer to speak a language other than English.
- Get information about Molina Healthcare, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.
- Receive instructions on how You can view online, or request a copy of, Molina Healthcare's non-proprietary clinical and administrative policies and procedures.
- Get a copy of Molina Healthcare's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina Healthcare's contracted hospitals.
- Not to be treated poorly by Molina Healthcare or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina Healthcare.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1 (888) 560-5716.

- Give information to Your doctor, provider, or Molina Healthcare that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed on with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare know about any fraud or wrong doing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active In Your Healthcare
Plan Ahead

- Schedule Your appointments at a good time for You
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long
- Keep a list of questions You want to ask Your doctor
- Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick

- Try to give Your doctor as much information as You can.
- Are You getting worse or are Your symptoms staying about the same?
- Have You taken anything?

If You would like more information, please call Molina Healthcare's Customer Support Center toll-free at 1 (888)-560-5716, Monday through Friday, between 8:00 a.m. and 7:00 p.m.

MOLINA HEALTHCARE SERVICES

Molina Healthcare is Always Improving Services

Molina Healthcare makes every effort to improve the quality of health care services provided to You. Molina Healthcare's formal process to make this happen is called the "Quality Improvement Process." Molina Healthcare does many studies through the year. If we find areas for improvement, we take steps that will result in higher quality care and service.

If You would like to learn more about what we are doing to improve, please call Molina Healthcare toll-free at 1 (888)-560-5716 for more information.

Your Healthcare Privacy

Your privacy is important to us. We respect and protect Your privacy. Please read our Notice of Privacy Practices, at the front of this Agreement.

New Technology

Molina Healthcare is always looking for ways to take better care of our Members. That is why Molina Healthcare has a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

Our Medical Directors find new medical procedures, treatment, drugs and devices when they become available. They present research information to the Utilization Management Committee where physicians review the technology. Then they suggest whether it can be added as a new treatment for Molina Healthcare Members.

For more information on new technology, please call Molina Healthcare's Customer Support Center.

What Do I Have to Pay For?

Please refer to the "Molina Healthcare of Florida, Inc. Benefits and Coverage Guide" at the front of this Agreement for Your Cost Sharing responsibilities for Covered Services.

Note that You may be liable to pay for the full price of medical services when:

- You ask for and get medical services that are not covered, such as cosmetic surgery.
- Except in the case of Emergency or out of area Urgent Care Services, You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare

If Molina Healthcare fails to pay a Molina Healthcare contracted provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the Participating Provider for any amounts owed by us. This is not true for non-Participating Providers who are not contracted with Molina Healthcare. For information on how to file a complaint if You receive a bill, please see below.

What if I have paid a medical bill or prescription?
(Reimbursement Provisions)

With the exception of any required Cost Sharing amounts (such as a Deductible, Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back. You will need to mail or fax us a copy of the bill from the doctor, hospital or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on the first page of this Agreement.

After we receive Your letter, we will respond to You within 30 days. If Your claim is accepted, we will mail You a check. If not, we will send You a letter telling You why. If You do not agree with this, You may appeal by calling Molina Healthcare toll-free at 1 (888)-560-5716, Monday through Friday, 8:00 a.m. to 7:00 p.m. ET.

How Does Molina Healthcare Pay for My Care?

Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina Healthcare does not provide financial incentives for utilization management decisions that could result in Referral denials or under-utilization. For more information about how providers are paid, please call Molina Healthcare's Customer Support Center toll-free at 1 (888)-560-5716, Monday through Friday, 8:00 a.m. to 7:00 p.m. ET. You may also call Your provider's office or Your provider's medical group for this information.

Interpreter Services
Do You speak a language other than English?

Many people do not speak English or are not comfortable speaking English. Please tell Your doctor's office or call Molina Healthcare if You prefer to speak a language other than English. Molina Healthcare can help You find a doctor that speaks Your language or have an interpreter help You.

Molina Healthcare offers telephonic interpreter services to help You with:

- Making an appointment
- Talking with Your doctor or nurse
- Getting Emergency care in a timely manner
- Filing a complaint or grievance
- Getting health education service
- Getting information from the pharmacist about how to take Your medicine (drugs
- Asking for a face-to-face or telephone interpreter to talk about medical conditions and treatment options

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina Healthcare sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina Healthcare's Customer Support Center at 1 (888)-560-5716.

Cultural and Linguistic Services
Molina Healthcare can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina Healthcare's Customer Support Center at 1 (888)-560-5716.

COMPLAINTS AND APPEALS

What if I Have a Complaint?

If You have a problem with any Molina Healthcare services, we want to help fix it. You can call any of the following toll-free for help:

- Call Molina Healthcare toll-free at 1 (888) 560-5716, Monday through Friday, 8:00 a.m. - 7:00 p.m. ET. Deaf or hard of hearing Members may call our toll-free TTY number at 1 (800) 955-8771. You may also contact us by calling the National Relay Service at 711 if You are deaf or hard of hearing.
- You may also send us Your problem or complaint in writing by mail or filing online at our website. Our address is:

Molina Healthcare of Florida, Inc.
Att: Complaints and Appeals Coordinator
PO Box 521838
Miami, Florida 33152-1838
Fax: 1-877-508-5748
www.molinahealthcare.com

Or You contact the Florida Department of Financial Services at

Department of Financial Services
Division of Consumer Services
200 E. Gaines Street
Tallahassee, FL 32399-0322
Toll-free: 1-877-693-5236
TDD: 1-800-640-0886

APPEALS

Definitions

The capitalized terms used in this appeals section have the following definitions:

"Adverse Benefit Determination": means

- A denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit;

- Any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet

Molina's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness; or

- Based in whole or in part on medical judgment, includes the failure to cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

- A decision by Molina to deny coverage based upon an initial eligibility determination.

An Adverse Benefit Determination is also a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such cancellation/discontinuance is due to a failure to timely pay required Premiums or contributions toward cost of coverage.

The denial of payment for services or charges (in whole or in part) pursuant to Molina's contracts with network providers, where You are not liable for such services or charges, are not Adverse Benefit Determinations.

"Authorized Representative": means an individual authorized in writing by You or state law to act on the Your behalf in requesting a health care service, obtaining claim payment, or during the internal appeal process. A health care provider may act on behalf of You without Your express consent when it involves an Urgent Care Service.

"DFS": means the Florida Department of Financial Services.

"Final Adverse Benefit Determination" means an Adverse Benefit Determination that is upheld after the internal appeal process. If the time period allowed for the internal appeal elapses without a determination by Molina Healthcare, then the internal appeal will be deemed to be a Final Adverse Benefit Determination.

"Post-Service Claim": means an Adverse Benefit Determination has been rendered for a service that has already been provided.

"Pre-Service Claim": means an Adverse Benefit Determination was rendered and the requested service has not been provided.

"Urgent Care Services Claim": means an Adverse Benefit Determination was rendered and the requested service has not been provided, where the application of non-urgent care appeal time frames could seriously jeopardize:

- Your life or health or the Your unborn child; or

- In the opinion of the treating physician, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Internal Appeal

Your, or Your Authorized Representative, or a treating Provider or facility may submit an appeal of an Adverse Benefit Determination. Molina will provide You with the forms necessary to initiate an appeal.

You may request these forms by contacting Molina at the telephone number listed on the Member ID card. While You are not required to use Molina's pre-printed form, Molina strongly encourages that an appeal be submitted on such a form to facilitate logging, identification, processing, and tracking of the appeal through the review process.

If You need assistance in preparing the appeal, or in submitting an appeal verbally, You may contact Molina for such assistance at:

Molina Healthcare of Florida, Inc.
Att: Complaints and Appeals Coordinator
PO Box 521838
Miami, Florida 33152-1838
1-888-560-5716
1-800-955-8771 TTY
Fax: 1-877-508-5748
www.molinahealthcare.com

If You are Hearing impaired You may also contact Molina via the National Relay Service at 711.

You (or Your Authorized Representatives) must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination.

Within five business days of receiving an appeal, Molina will send You (or Your Authorized Representative) a letter acknowledging receipt of the appeal.

The appeal will be reviewed by personnel who were not involved in the making of the Adverse Benefit Determination and will include input from health care professional in the same or similar specialty as typically manages the type of medical service under review.

TIMEFRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIMEFRAME FOR DECISION**
URGENT CARE SERVICE	WITHIN 72 HOURS.
PRE-SERVICE AUTHORIZATION	WITHIN 30 DAYS.
CONCURRENT SERVICE (A REQUEST TO EXTEND OR A DECISION TO REDUCE A PREVIOUSLY APPROVED COURSE OF TREATMENT)	WITHIN 72-HOURS FOR URGENT CARE SERVICES AND 30-DAYS FOR OTHER SERVICES.
POST-SERVICE AUTHORIZATION	WITHIN 60 DAYS.

Exhaustion of Process

The foregoing procedures and process are mandatory and must be exhausted prior to establishing litigation or arbitration or any administrative proceeding regarding matters within the scope of this Complaints and Appeals section.

External Appeal

After You have exhausted the internal appeal rights provided by Molina, You have the right to request an external/independent review of this adverse action. You (or Your Authorized Representative) may file a written request for an external review. Your notice of Adverse Benefit Determination and Final Adverse Benefit Determination describes the process to follow if You wish to pursue an external appeal.

You must submit your request for external review within 123 calendar days of the date You receive the notice of Adverse Benefit Determination or Final Adverse Benefit Determination.

You can request an external appeal in writing by sending it electronically to DisputedClaim@opm.gov; or by faxing it to 202-606-0036, or by sending it by mail to:

Office of Personnel Management (OPM)
P.O. Box 791
Washington, DC 20044.

If You have any questions or concerns during the external appeal process, You (or Your Authorized Representative) can call the toll-free number 877-549-8152. You (or Your representative) can submit additional written comments to the external reviewer at the mailing address above. If any additional information is submitted, it will be shared with Molina in order to give us an opportunity to reconsider the denial.

Request for expedited external appeal – You (or Your representative) may make a written or oral request for an expedited external appeal with the external reviewer when You receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an appeal of an Urgent Care Service would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for a review of an Urgent Care Service; or

- A Final Adverse Benefit determination, if You have a Medical Condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

- An Adverse Benefit Determination that relates to Experimental or Investigational treatment, if the treating physician certified that the recommended or requested health care service, supply, or treatment would be significantly less effective if not promptly initiated.

In expedited external appeal situations, requests for expedited review can be initiated by calling the OPM toll free number 877-549-8152.

Additionally, at Your request, Molina can send You copies of the actual benefit provision, and will provide a copy at no charge, of the actual benefit, clinical guidelines or clinical criteria used to make the determination upon receipt of Your request. A request can be made by calling the Molina Complaints and Appeals Coordinator.

General Rules and Information

General rules regarding Molina's Complaint and Appeal Process include the following:

- You must cooperate fully with Molina in Our effort to promptly review and resolve a complaint or appeal. In the event You do not fully cooperate with Molina, You will be deemed to have waived Your right to have the Complaint or Appeal processed within the time frames set forth above.

- Molina will offer to meet with You by telephone. Appropriate arrangement will be made to allow telephone conferencing to be held at Our administrative offices. Molina will make these telephone arrangements with no additional charge to You.

- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination.

- Molina will provide You with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when the initial Adverse Benefit Determination was made. A "full and fair" review process requires Molina to send any new medical information to review directly so You have an opportunity to review the claim file.

Telephone Numbers and Addresses

You may contact a Molina Complaints and Appeals Coordinator at the number listed on the acknowledgement letter or notice of Adverse Benefit Determination or Final Adverse Benefit Determination. Below is a list of phone numbers and addresses for complaints and appeals.

Department of Financial Services
Division of Consumer Services
200 E. Gaines Street
Tallahassee, FL 32399-0322
Toll-free: 1-877-693-5236
TDD: 1-800-640-0886

Molina Healthcare of Florida, Inc.
Attn: Complaints and Appeals Coordinator
PO Box 521838
Miami, Florida 33152-1838
1-888-560-5716
1-800-955-8771 TTY
Fax: 1-877-508-5748
www.molinahealthcare.com

BINDING ARBITRATION

OPTION TO RESOLVE ALL DISPUTES EXCEPT MEDICAL MALPRACTICE BY BINDING ARBITRATION

******Important Information About Your Rights******

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product (except for claims of medical malpractice which would be governed by Chapter 766 of the Florida Statute ("F.S.") and which are expressly excluded) between Member (including any heirs, successors or assigns of the Member) and Molina Healthcare, or any of its parents, subsidiaries, affiliates, successors or assigns may be submitted to binding arbitration in accordance with applicable state and federal laws, including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, the Florida Arbitration Act, Chapter 682 F.S. *et seq.*, and the Affordable Care Act. Any such dispute will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Arbitration shall not preclude review pursuant to Rule 69O-191.081 of the Florida Administrative Code. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

Member and Molina Healthcare acknowledge that, by agreeing to arbitrate, they will waive the right to trial by jury or to participate in a class action. Through binding arbitration, Member and Molina Healthcare will give up their constitutional rights to have any such dispute decided in a court of law before a jury. If Member agrees to submit a dispute to binding arbitration, Member further agrees to the following:

- The final and binding arbitration shall be conducted in accordance with the AAA Commercial Arbitration Rules and Mediation Procedures, and administration of the arbitration shall be performed by the AAA or such other arbitration service as the parties may agree in writing. Judgment upon the award

rendered by the arbitrator may be entered in any court having jurisdiction.

- The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the AAA Commercial Arbitration Rules and Mediation Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

- Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the Florida Arbitration Act. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Florida state law court, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

- The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. Proceeding with binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

- The parties shall divide equally the costs and expenses of the AAA and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of AAA and the arbitrator, provided the Member submits a hardship application to the AAA. The

hardship application shall be made in a manner and with the information and any documentation as required by the AAA. The AAA (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

- Member acknowledges that care, diagnosis and treatment will be provided whether or not the Member agrees to binding arbitration.

IN PROCEEDING WITH ARBITRATION, THE PARTIES WILL WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND WOULD INSTEAD ACCEPT THE USE OF BINDING ARBITRATION.

OTHER

MISCELLANEOUS PROVISIONS

Acts Beyond Molina Healthcare's Control
If circumstances beyond the reasonable control of Molina Healthcare, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina Healthcare and the Participating Provider shall provide or attempt to provide Benefits and Coverage insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina Healthcare nor any Participating Provider shall have any liability or obligation for delay or failure to provide Benefits and Coverage if such delay or failure is the result of any of the circumstances described above.

Waiver
Molina Healthcare's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement, or impair Molina Healthcare's right to require Your performance of any provision of this Agreement.

Non-Discrimination
Molina Healthcare does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1 (888) 560-5716.

Organ or Tissue Donation
You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the

number of patients in need of an organ transplant. You may choose to be an organ tissue donor by registering with the Florida Agency for Health Care Administration by going online at http://www.donatelifeflorida.org/ to add your name to the registry.

Agreement Binding on Members
By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with Florida law and any provision that is required to be in this Agreement by state or federal law shall bind Molina Healthcare and Members whether or not set forth in this Agreement.

Invalidity
If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding or binding arbitration, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.

Notices
Any notices required by Molina Healthcare under this Agreement will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address.

HEALTH EDUCATION SERVICES

The tools and services described here are educational support for our Members. We may change them at any time as necessary to meet the needs of our Members.

Education and Information about Health and Disease
Molina Healthcare offers many tools to help keep You and Your family healthy. You may ask for brochures on many topics such as:

- Eating healthy
- Preventive Service Guidelines (“Grow and Stay Healthy”)
- Reducing stress
- Starting an exercise program
- Choosing a birth control method
- Drug and alcohol use
- Weight management
- Asthma
- Diabetes management
- Cholesterol management
- High blood pressure

We also offer programs to help You manage Your current health conditions. These include weight management and smoking cessation. If You want to learn about these programs, a Molina Care Manager may contact You. You can also enroll in any of these programs by calling the Molina Healthcare Health Education Department at 1888-560-5716, between 8:00 a.m. and 7:00 p.m., Monday through Friday.

Molina Healthcare's Health Education Department is committed to helping You stay well. Find out if You are eligible to sign up for one of our programs. Ask about other services we provide or request information to be mailed to You. The following are a list of programs and services Molina Healthcare has to offer You.

Call toll-free 1 888-560-5716 (Monday through Friday, 8:00 a.m. –7:00 p.m.).

Motherhood MattersSM

A Prenatal Care Program for Pregnant Women
Pregnancy is an important time in Your life. It can be even more important for Your baby. What You do during Your pregnancy can affect the health and well-being of Your baby – even after birth.

Motherhood Matters is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. You will be mailed a workbook and other resources. It is offered in six languages.

You will be able to talk with our caring staff about any questions You may have during the pregnancy. They will teach You what You need to do. If any problems are found, a nurse will work closely with You and Your doctor to help You. Being a part of this program and following the guidelines will help You have a healthy pregnancy and a healthy baby.

Your Baby's Good Health Begins When You Are Pregnant
You Learn:

- Why visits to Your doctor are so important.
- How You can feel better during pregnancy.
- What foods are best to eat.
- What kinds of things to avoid.
- Why You should stay in touch with Molina Healthcare's staff.
- When You need to call the doctor right away.

Other Benefits

- Health Education Materials – These include a pregnancy book and trimester specific materials.
- Referrals – To community resources available for pregnant women.

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. Specialized services are available for teens, pregnant smokers and tobacco chewers. The program is done over the telephone. You will also be mailed educational materials to help You stop the

habit. A smoking cessation counselor will call You to offer support. You will also be given a telephone number that You can call anytime You need help.

Weight Control Program
This program is for Members who need help controlling their weight.

The weight control program is provided for Members 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program and attend classes in Your area.

Health Education Materials
Molina Healthcare offers a variety of easy-to-read educational materials. Many are available in different languages. Some of the topics are on nutrition, stress management, child safety, asthma, and diabetes. You can get any of these materials by asking Your doctor. You can also call the Health Education Department at 1-888-560-5716.

Your Healthcare Quick Reference Guide

Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina Healthcare's services, we want to help fix it. You can call our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 a.m. to 7:00 p.m. ET. When in doubt, call us first.	**Customer Support Center Toll Free:** 1 (888) 560-5716 **TTY line for the deaf or hard of hearing:** 1 (800) 955-8771 or dial 711 for the National Relay Service
Health Education	To request any information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes.	1 (888) 560-5716
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 **for Spanish:** 1 (866) 648-3537
Motherhood Matters	Molina Healthcare offers a special program called Motherhood Matters to our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that we have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(415) 437-8310 **TDD for deaf or hard of hearing:** (415) 437-8311 **FAX:** (415) 437-8329
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE **TTY for deaf or hard of hearing:** 1 (877) 486-2048 **www.Medicare.gov**
Department of Financial Services	The Florida Department of Financial Services is responsible for regulating health care services plans. If You have a grievance against Your health plan, You should first call Molina Healthcare toll-free at 1(888) 560-5716, and use Molina Healthcare's grievance process before contacting this department.	**www.myfloridacfo.com** 1 (877)-693-5236 or TDD: 1 (800) 640-0886.

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