2019

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

Molina Marketplace – Silver 250 Plan

FLORIDA

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

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE, YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PRODUCT FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

MolinaMarketplace.com

Service Area: Counties of Broward, Duval, Hillsborough, Miami-Dade, Osceola, Pinellas, Palm Beach, Polk

MOLINA HEALTHCARE
Your Extended Family.

Officer's Signature

Michael J. Jones, Plan President

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019; TTY (800) 537-7697.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجانًا، لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه؛ اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، بدون هزینه در دسترس شما هستند. با خدمات اعضا تماس بگیرید. شماره تلفن روی پشت کارت شناسایی عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ.ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

FLORIDA – SILVER 250 PLAN

MOLINA HEALTHCARE OF FLORIDA, INC.
SCHEDULE OF BENEFITS

THE GUIDE BELOW IS INTENDED TO HELP YOU DETERMINE BENEFITS COVERAGE 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, LIMITATIONS, AND EXCLUSIONS.

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

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$5,350
Entire Family of 2 or more Members	$10,700
Prescription Drug Deductible	
Individual	$400
Entire Family of 2 or more Members	$800
Annual Out-of-Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$7,900
Entire Family of 2 or more	$15,800

[1] Medically Necessary Emergency Services furnished by a Non-Participating Provider will apply to Your Annual Out-of-Pocket Maximum.

Emergency Services and Urgent Care Services[2]	**You Pay**	
Emergency Services[3] (Applies to Facility Charges Only)	30%	Coinsurance after Deductible
Urgent Care Services (Services must be provided by a Participating Provider facility.)	$50	Copayment per visit

[2] Please refer to the section of the Agreement titled "Emergency Services and Urgent Care Services" for more information.

[3] This cost does not apply if admitted directly to the hospital for inpatient services. Refer to "Inpatient Hospital Services" below for applicable Cost Sharing information.

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Outpatient Professional Services[4]		**At Participating Providers, You Pay**	
Office Visits[5]			
Preventive Care (Includes prenatal and first postpartum exam)		No Charge	
Primary Care (PCP) and Other Practitioner Care		$30	Copayment per visit
Specialty Care		$75	Copayment per visit
Habilitative Services		$75	Copayment per visit
Rehabilitative Services		$75	Copayment per visit
Mental/Behavioral Health Services		$30	Copayment per visit
Substance Abuse Disorder Services		$30	Copayment per visit
Dental Services Related to Accidental Injury		30%	Coinsurance
Family Planning		No Charge	
Pediatric Vision Services (for Members up to age 26, or up to age 30 as determined by Florida law)			
Vision Exam (Screening and exam, limited to 1 exam each calendar year)		No Charge	
Prescription Glasses		No Charge	
Frames	• Limited to one pair of frames every 12 months • Limited to a selection of covered frames		
Lenses	• Limited to 1 pair once every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, UV protection	No Charge	
Prescription Contact Lenses (In lieu of prescription glasses, limited to 1 pair of standard contact lenses every calendar year. Medically Necessary contact lenses for specified medical conditions require Prior Authorization.)		No Charge	
Low Vision Optical Devices and Services (Subject to limitations. Prior Authorization applies.)		No Charge	

[4] Please note, if You are seen in a hospital-based clinic, outpatient hospital Cost Sharing may apply.

[5] For laboratory and diagnostic x-ray services that are provided in a PCP's or Specialist Physician's office, on the same date of service as a PCP or Specialist Physician office visit, You will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and x-ray Cost Sharing, as shown in the Schedule of Benefits, will apply if services are provided by a Participating Provider at a separate location, even if on the same day as an office visit.

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Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgical and Non-Surgical Services		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)[6]	30%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	$75	Copayment
Laboratory Tests	$40	Copayment
Mental/Behavioral Health		
Outpatient Intensive Psychiatric Treatment Programs	30%	Coinsurance after Deductible

[6] Unless Specialized Scanning Services are performed while You are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.

Inpatient Hospital Services	At Participating Providers, You Pay	
Medical / Surgical		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Maternity Care (Professional and Facility services)	30%	Coinsurance after Deductible
Mental/Behavioral Health (Inpatient Psychiatric Hospitalization)	30%	Coinsurance after Deductible
Substance Abuse Disorder		
Inpatient Detoxification	30%	Coinsurance after Deductible
Transitional Residential Recovery Services	30%	Coinsurance after Deductible
Skilled Nursing Facility[7] (Limited to 60 days per calendar year)	30%	Coinsurance after Deductible
Hospice Care	No Charge	

[7] Services must be billed by a Skilled Nursing Facility Participating Provider.

Prescription Drug Coverage[8]	At Participating Providers, You Pay	
Tier-1 Drugs	$20	Copayment
Tier-2 Drugs	$60	Copayment
Tier-3 Drugs	40%	Coinsurance after Deductible
Tier-4 Drugs	40%	Coinsurance after Deductible
Tier-5 Drugs	No Charge	
Mail-Order Prescription Drugs	A 90-day supply is offered at two times the 30-day prescription Cost Sharing.	

[8] For details, please refer to the Agreement section titled "Prescription Drug Coverage." Please note, Cost Sharing reduction for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third-party Cost Sharing assistance, will not apply toward any Deductible or the Annual Out-of-Pocket Maximum under Your Plan.

Ancillary Services	At Participating Providers, You Pay
Durable Medical Equipment	No Charge after Deductible
Home Health Care[9] (Limited to 60 visits per calendar year)	No Charge

Emergency Medical Transportation	You Pay	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered; however, You may be responsible for provider charges that exceed the allowed amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.)	30%	Coinsurance, plus amounts that exceed the Allowed Amount

[9] Services must be billed by a Home Healthcare Participating Provider agency. Separate Cost Sharing may apply for other Covered Services delivered in the home setting (e.g., injectable drugs).

Other Services	At Participating Providers, You Pay	
Dialysis Services	$75	Copayment

Table of Contents

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,**" "**Our**" or "**Us**"), 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 agrees to provide the Benefits and Coverage Covered Services as described in this Agreement.

This Agreement and any application(s) submitted to the Marketplace and/or Molina 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 and the Subscriber.

WELCOME

Welcome to Molina Healthcare!

Here at Molina, We will help You meet Your medical needs.

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

Molina is a Florida licensed Health Maintenance Organization.

We can help You understand this Agreement. If You have any questions about anything in this Agreement, call Us. You can call if You want to know more about Molina. You can get this information in 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
MolinaMarketplace.com

If You are deaf or hard of hearing, You may contact Us via TTY at 1 (800) 955-8771 or by dialing 711 for the Telecommunications Relay Service.

INTRODUCTION

Thank You for choosing Molina as Your health plan

This document is 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. It sets out the terms and conditions of coverage under this product. It sets out Your rights and responsibilities as a Molina Member and describes how to contact Molina. Please read this Agreement 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 is here to serve You

Call Molina if You have questions or concerns. Our helpful and friendly staff will be happy to help You. We can help You:

- Arrange for an interpreter.
- Check on authorization status.
- Choose a Primary Care Provider (PCP).
- Make a payment.
- Make an appointment.

We can also listen and respond to Your questions or complaints about Your Molina benefits.

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 via TTY at 1 (800) 955-8771, or by dialing 711 for the Telecommunications Relay Service.

Call Us if You move from the address You had when You enrolled with Molina or if You change phone numbers.

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 need Your written authorization (approval) to use or share Your PHI?

Molina 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. 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 next section of this EOC. It is also on Our web site at MolinaMarketplace.com. You may also get a copy of Our Notice of Privacy Practices. Call 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**," "**Our**" or "**Us**") 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 Physician. This helps the Specialist Physician 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 Your PHI 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

- Addressing 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 U.S. 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 any reason not 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 U.S. 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:

Grievance and Appeals
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
8300 NW 33rd Street, Suite 400
Doral, Florida 33122
1 (888) 560-5716
MolinaMarketplace.com

HELP FOR NON-ENGLISH SPEAKING MOLINA MEMBERS

Interpreter Services

As a Molina 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 via TTY at 1 (800) 955-8771 or by dialing 711 for the Telecommunications Relay Service.

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

DEFINITIONS

Some of the words used in this Agreement 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 Agreement, We explain what it means in that section. Words with special meaning used in any section of this Agreement are explained in this "Definitions" section and are capitalized throughout this Agreement.

"**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.

"**Allowed Amount**" means the maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing.

Services obtained from a Participating Provider: This means the contracted rate for such Covered Service.

Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of 1) Molina's median contracted rate for such service(s), 2) 100% of the published Medicare rate for such service(s), or 3) Molina's usual and customary method for determining payment for such service(s).

All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service, 100% of the published Medicare rate for such service, Molina's usual and customary rate for such service, or a negotiated amount agreed to by the Non-Participating Provider and Molina.
"**Annual Out-of-Pocket Maximum**" (also referred to as "**OOPM**") is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1) the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
2) the family OOPM will be met when Your family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family .

"**Child-Only Coverage**" means coverage under this Agreement to provide benefit coverage only to a

child who, as of the beginning of a plan year, has not attained the age of 21, and meets all other eligibility requirements for coverage under this product.

"**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 has negotiated with the Participating Provider. Coinsurances are listed in the Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible and/or Copayment.

"**Complications of Pregnancy**" is a condition diagnosed as separate from a pregnancy. Complications means a condition requiring hospital confinement whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Schedule of Benefits. Some Covered Services do not have a Copayment and may apply a Deductible and/or Coinsurance.

"**Cost Sharing**" is the Deductible, Copayment, and/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 Schedule of Benefits at the beginning of this Agreement.

"Covered Services" refers to all the healthcare services, including supplies, and prescription drugs covered by the Agreement and that You are entitled to receive from Molina under this Agreement.

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina 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 has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Agreement.

Please refer to the Schedule of Benefits 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 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. However, for preventive services covered by this Agreement and included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services when provided by a Participating Provider.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

(i) when You meet the Deductible for the individual Member; or
(ii) when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible.

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent as described in the "Eligibility and Enrollment" section of this Agreement.

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

"**Durable Medical Equipment**" or "**DME**" is medical equipment that serves a repeated medical purpose and serves for repeated use. DME 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
- 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**" means 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. If an Emergency Medical Condition exists, Emergency Services includes 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 offered by Molina 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 26, or under the age of 30 as determined by Florida law

*****Pediatric dental services are not covered under this Agreement. These dental services can be purchased

separately through a stand-alone dental product that is certified by the Marketplace.

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

"**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. 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. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must also be deemed by Molina to be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration;
- Effective for the patient's illness, injury or disease; and,
- Not primarily for the convenience of the patient, physician, or other health care provider. The services must not be 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 based on credible scientific evidence published in peer-reviewed medical literature. This literature is 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 Dependent and a Subscriber, unless the Subscriber is not applying for coverage on their own behalf, but is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a minor child who, as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this product but will not be a Member. Throughout this Agreement, "You" and "Your" may be used to refer to a Member or Subscriber, as the context requires.

"**Molina Healthcare of Florida, Inc. Agreement and Individual Evidence of Coverage**" (also "**Agreement**" or "**EOC**") means this document, which has information about Your benefits.

"**Molina Healthcare of Florida, Inc.** (also "**Molina Healthcare**" or "**Molina**" or "**We**" or "**Our**" or "**Us"**)" means the corporation licensed in the State of Florida as a Health Maintenance Organization and contracted with the Marketplace.

"**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 PCPs 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 Provider**" (also "**PCP**") is the doctor who takes care of Your health care needs. Your PCP has Your medical history. Your PCP makes sure You get needed health care services. A PCP may refer You to Specialist Physicians or other services. A PCP may be one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family
- Internal medicine doctor, who usually only sees adults and children 14 years or older
- Pediatrician, who sees children from newborn to age 18 or 21
- Obstetrician and gynecologist (OB/GYN)
- Osteopathic physicians
- Podiatrist
- Chiropractor
- Individual practice association (IPA) or group of licensed doctors that provides primary care services

"Prior Authorization" means Molina's prior determination for Medical Necessity of Covered Services before services are provided. Prior Authorization is not a guarantee of payment for services. Payment is made based upon the following:

- benefit limitations
- exclusions
- Member eligibility at the time the services are provided
- other applicable standards during the claim review.

"Referral" means the process by which the Member's PCP directs him or her to seek and obtain Covered Services from other providers.

"**Service Area**" means the geographic area in the State of Florida where Molina 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 Covered Services 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 is a Participating Provider.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this Agreement, the term "Spouse" includes the Subscriber's same-sex.

"**Subscriber**" means either:

- An individual who is a resident of Florida, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accordance with the terms of this Agreement. This includes an individual who is not a minor and is applying on their own behalf for Child-Only Coverage under this Agreement; or

- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a minor child, who as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of the Member under this Agreement.

Throughout this EOC, "You" and "Your" may be used to refer to a Member or a Subscriber, as the context requires.

"Telehealth and Telemedicine Services" means:

- Delivery of Covered Services by a Participating Provider through audio and video conferencing technology that permits communication between a Member at an originating site and a Participating Provider at a distant site, allowing for the diagnosis or treatment of Covered Services.
- The communication does not involve in-person contact between the Member and a Participating Provider. During the virtual visit, the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.
- Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Requirement: When using "Store and Forward" technology, all covered services must also include an in-person office visit to determine diagnosis or treatment.

"**Urgent Care Services**" means 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 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 that You are accepted by the Marketplace and/or Molina.

For coverage during the calendar year 2019, the initial open enrollment period begins November 1, 2018, and ends December 15, 2018. Your Effective Date for coverage during 2019 will depend on when You apply.

- If You apply on or before December 15, 2018, the Effective Date of Your coverage is January 1, 2019.
- Applications made after December 15, 2018, are subject to Special Enrollment Period requirements and verification.

If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period. You must be eligible under the special enrollment procedures established by the Marketplace. In such case, the Effective Date of coverage will be as determined by the Marketplace and/or Molina. Without limiting the above, the Marketplace and/or Molina 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. The Marketplace establishes the eligibility requirements. Check the Marketplace's website at healthcare.gov for eligibility criteria.

Molina requires You to live in Molina's Service Area to be eligible under this product. For Child-Only Coverage, the Member must be under the age of 21 at the beginning of the plan year, and in the case of a Subscriber who applies for coverage on behalf of a minor child, the Subscriber must be a responsible adult (parent or legal guardian). If You have lost Your eligibility, as described in the section titled "When Will My Molina Membership End? (Termination of Covered Services)," You may not be permitted to re-enroll.

Child-Only Coverage: Additional children can be added to Child-Only Coverage provided that each child is under the age of 21 at the beginning of the plan year, and if a child is a minor, that a responsible adult (parent or legal guardian) applies for the Child-Only Coverage on behalf of the minor child.

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 requires Dependents to live in Molina's Service Area to be eligible under this product. The following types of family members are considered Dependents under an Agreement that is not for Child-Only Coverage (refer to "Child-Only Coverage" section, above, for information on adding children to Child-Only Coverage):

- Spouse

- Children
  - The Subscriber's children or the Spouse's children (including legally adopted children, foster children, and stepchildren)
  - Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age)

Domestic Partners: If permitted by the Marketplace, a domestic partner of the Subscriber may enroll in this product. The domestic partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace and/or Molina.

Age Limit for Children (Children with Disabilities)

Children who reach the limiting age of age 26 are eligible to continue enrollment as a Dependent for coverage, except in Child-Only Coverage, if all of the following conditions apply:

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

A disabled child may remain covered by Molina 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 26 until the end of the calendar year in which the child turns 30 years of age. The child will remain eligible only if the following requirements are met:

- The child is unmarried and does not have a dependent of his or her own;
- The child is a resident of Florida or a full-time or part-time student; and
- The child 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 26 and the coverage for the child is subsequently terminated prior to the end of the calendar year in which the child turns age 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 63 days.

Adding New Dependents

To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber are enrolled, You must contact the Marketplace (1-800-318-2596) and/or Molina and submit any required application(s), forms, and requested information for the Dependent. Examples of new dependents may include a spouse, a newborn child, or a newly adopted child. You must submit requests to enroll a new Dependent within 60 days from the date the Dependent became eligible to enroll with Molina.

- **Spouse**

  You can add a Spouse as long as You apply during one of the following:

  - The open enrollment period

  - 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
  - Any other coverage designated as “minimum essential coverage” in compliance with the Affordable Care Act
- The date of Your marriage
- The date the Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status
- The Spouse permanently moves into the service area
- A qualified individual's enrollment or non-enrollment that is the result of an error, misrepresentation, or inaction of the Marketplace.
- A qualified health plan in which the Spouse is enrolled violates a material provision of its contract in relation to the enrollee

- **Children Under 26 Years of Age**

  You can add a Dependent under the age of 26, including a stepchild, except in Child-Only Coverage, as long as You apply during one of the following:

  - The open enrollment period
  - 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
      - Any other coverage designated as “minimum essential coverage” as determined by the Affordable Care Act
    - The child becomes a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, child support or other court order
    - The child, who was not previously a citizen, national, or lawfully present individual, gains such status
    - The child permanently moves into the service area
    - A qualified individual's enrollment or non-enrollment that is the result of an error, misrepresentation, or inaction of the Marketplace.

- A qualified health plan in which the child is enrolled violates a material provision of its contract in relation to the enrollee

- **Newborn Child**

  Coverage for a newborn child is from the moment of birth and will continue for 31 days. This includes the newborn child's 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 do not 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. 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)**

  A newborn child of a Covered Dependent child may be covered for a period of up to 18 months from birth under the following conditions:

  - The Covered Dependent child must be enrolled before the end of the Calendar Year in which the Covered Dependent child turns age 26; and
  - The newborn child of the Covered Dependent child must be enrolled within 60 days of birth.

- **Adopted Child**

  If You adopt a child or a child is placed with You for adoption, then the child is eligible for coverage under this Agreement. The child can be added to this Agreement during the open enrollment period, within 60 days of the child's adoption or within 60 days of the child's placement with You for adoption. The child's coverage shall be effective on the date of adoption, placement for adoption or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

- **Court Order or Child Support Order**

  If a child becomes a dependent of You or Your spouse through a child support order or other court order, then the child shall be eligible for coverage under this Agreement. A Dependent can be added to this Agreement during the open enrollment period or within 60 days of the effective date of the court order. The child shall be eligible for coverage on the date the court order is effective or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

- **Foster Child**

  If a child is placed with You or Your spouse for foster care, then the child shall be eligible for coverage under this Agreement. A foster child can be added to this Agreement during the open enrollment period or within 60 days of the child's placement with You in foster care. The child's coverage shall be effective on the date of placement in foster care or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

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

Discontinuation of Dependent Covered Services

Except under Child-Only Coverage, Covered Services for Your Dependent will be discontinued on:

- The last day of the calendar year that the Dependent child attains age 26, unless the child meets specified criteria. See the above sections titled "Age Limit for Children (Disabled Children)" and "Continued Eligibility of Certain Children Beyond the Limiting Age of 26" for more information.

- The date the Dependent Spouse enters a final decree of divorce, annulment, or dissolution of marriage from the Subscriber.

- For Child-Only Coverage, the date You are no longer eligible.

MEMBER IDENTIFICATION CARD (ID CARD)

How Do I Know if I Am a Molina Member?

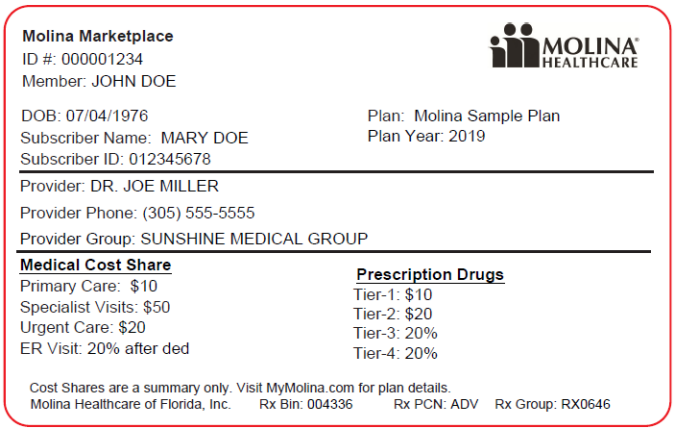
You get a Member identification card (ID card) from Molina. Your ID card comes in the mail within 10 business days after You make Your first payment. Your ID card lists Your PCP's name and phone number.

Carry Your ID card with You at all times. You must show Your ID card every time You get health care.

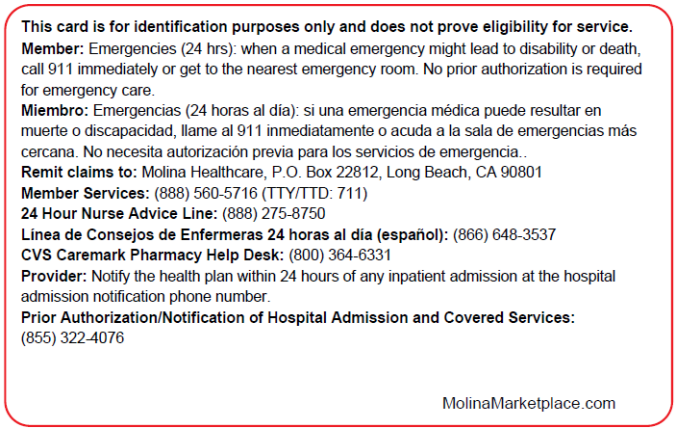
If You lose Your ID card, you can get a temporary ID card at **mymolina.com**, and you can request a new ID card at **mymolina.com** or by calling Molina toll-free at 1 (888) 560-5716. We will be happy to send You a new card. Call Us if You have questions about how to use Your health care benefits.

Sample ID Card:

Front:



Back:



What Do I Do First?

Look at Your Molina Member ID card. Check that Your name and date of birth are correct.

Your ID card will tell You the name of Your doctor. This person is called Your Primary Care Provider, 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 PCP's name (Provider)
- Your PCP's office phone number (Provider Phone)
- The name of Your PCP's medical group (Provider Group)
- The toll-free number for Molina's 24-hour Nurse Advice Line
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- The toll-free number for prescription-related questions
- The identifier for Molina's prescription drug benefit
- The toll-free number for hospitals to notify Molina of admissions for Our Members

- The toll-free number for emergency rooms to notify Molina emergency room visits for Our Members

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

ACCESSING CARE

How Do I Get Medical Services Through Molina?

PLEASE READ THE FOLLOWING INFORMATION. IT TELLS YOU FROM WHOM OR WHAT GROUP OF PROVIDERS YOU CAN GET HEALTH CARE SERVICES.

Molina's Provider Directory includes a list of the PCPs and hospitals that are available to You as a Member of Molina. You may visit Our website at MolinaMarketplace.com to view Our online list of the Participating Providers. You may also call Our Customer Support Center to request a paper copy.

Except in an Emergency, the first person You should call for any healthcare is Your PCP. If needed, Your PCP will give You a **Referral** to another doctor or to a hospital. For more information, refer to the section of this Agreement titled, "Referrals."

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 or where they are located, call Molina toll-free at 1 (888) 560-5716.

You may get Emergency Services in any emergency room, wherever located.

In general, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider:

1) for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services",
2) for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"
3) for exceptions described in the section of this Agreement titled "Second Opinions From Non-Participating Providers."

Telehealth and Telemedicine Services

You may obtain Covered Services by Participating Providers through the use of Telehealth and Telemedicine Services. Not all Participating Providers offer these services. For more information, please refer to "Telehealth and Telemedicine Services" in the definitions section. The following additional provisions apply to the use of Telehealth and Telemedicine Services:

- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Member Cost Sharing associates to the Schedule of Benefits, based upon the Participating Provider's designation for Covered Services. (i.e., Primary Care, Specialist or Other Practitioner).
- Covered Services provided through Store and Forward technology must include an in-person office visit to determine diagnosis or treatment.

Here is a chart that tells You where to go for medical services. The services You may need are listed in the boxes on the left. The right side tells You whom to call or where to go.

ALWAYS CONSULT YOUR PCP FIRST, EXCEPT FOR EMERGENCIES	
TYPE OF HELP YOU NEED:	**WHERE TO GO, WHOM TO CALL:**
Emergency Services	Call **911** or go to the nearest emergency room. Even when outside Molina's network or Service Area, please call 911 or go to the nearest emergency room for Emergency Services.
Urgent Care Services	Only Participating Provider urgent care centers are covered. No Prior Authorization or Referral is required. You may also call Your PCP or call Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish, call 1 (866) 648-3537. For out-of-area Urgent Care Services You may also go to the nearest 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** • **Birth control** • **Sterilization**	Go to any Participating Provider of Your choice. You do not need a Prior Authorization for these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization for 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 Our Customer Support Center if You do not know an OB/GYN.
For mental/behavioral health or substance abuse evaluation or therapy	Go to a mental/behavioral health or substance abuse Participating Provider. You do not need a Referral or Prior Authorization for evaluation or outpatient office visits. To find a Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. Your PCP will give You a Referral if needed. If You need Emergency Services or Urgent Care Services, get help as directed under "Emergency Care" or "Urgent Care Services" above.
To get a second opinion	Go to Your PCP for a Referral. You can find a Participating Provider for a second opinion in Molina's Provider Directory at MolinaMarketplace.com. In some cases, You may obtain a second opinion from the provider of your choice without a Referral, including from a provider that is not in the Molina Provider Directory. To learn more, read the section of this Agreement titled "Second Opinions."
To go to the hospital	If You need Emergency Services or Urgent Care Services, get help as directed under "Emergency Services" or "Urgent Care Services" above. For non-emergency, go to Your PCP first. Your PCP will give You a Referral if needed.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate urgent care center. You can also call Our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537.

What is a Primary Care Provider (PCP)?

A 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 doctors, call Our 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 provided by Molina Participating Providers (doctors, hospitals, Specialist Physicians, and medical clinics), except in the case of Emergency Services. For more information, please refer to the section titled "Emergency Services and Urgent Care 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 this Agreement. You will also learn some helpful tips on how to use the services and benefits covered under this Agreement. Molina's Provider Directory can be found on Our website at MolinaMarketplace.com under Find A Doctor or Pharmacy.

You can find the following in Our Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Specialties
- Professional qualifications (e.g., board certification)

You can also find out if a Participating Provider (PCP or Specialist Physician) is accepting new patients.

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.
This may include:

- **Family planning**
- **Birth control, including Emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **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 PCP?

It is easy to choose a PCP. Use Our Provider Directory to select from a list of doctors.

You may want to choose one doctor who will see Your whole family. You can also choose one doctor for Yourself and another for each family member.

You may choose a physician who specializes in pediatrics as a child's PCP. The pediatrician must be a Participating Provider with Molina.

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 are comfortable with Your PCP selection.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Us toll-free at 1 (888) 560-5716.

Molina 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 doctor.

What if I Do Not Choose a PCP?

We ask that You select a PCP within 30 days of joining Molina. If You do not choose a PCP, We will choose one for You.

Changing Your Doctor

What if I Want to Change my PCP?

You can change Your PCP at any time.

- Changes made by the 25th of the month will be in effect on the first day of the following calendar month.

- Changes made on or after the 26th of the month will be in effect on the first day of the second calendar month.

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 doctor.

Can My Doctor Request That I Change to a Different PCP?

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
- Your relationship with Your PCP breaks down

How Do I Change my PCP?

You may change your PCP by logging on at MyMolina.com. You may also Call Us toll-free at 1 (888) 560-5716, Monday through Friday, 8:00 a.m. to 7:00 p.m. ET. Visit Our website at MolinaMarketplace.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.
- 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?

If Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina, 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, You can choose a different doctor. Our 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, then Molina will provide You 60 days advance written notice. We will advise You about the contract ending between Molina and the PCP or hospital.

Continuity of Care

If You are receiving an Active Course of Treatment for Covered Services from a Participating Provider whose participation with Molina is ending without cause, You may have a right to continue receiving Covered Services from that provider until the Active Course of Treatment is complete or for 6 months, whichever is shorter, at in-network Cost Sharing.

For purposes of this "Continuity of Care" section, the following capitalized terms have the meanings described below:

An "Active Course of Treatment" is:

1) an ongoing course of treatment for a Life-Threatening Condition;
2) an ongoing course of treatment for a Serious Acute Condition;
3) all trimesters of pregnancy, through the postpartum period; or
4) an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes

A "Life-Threatening Condition" is:

- a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

A "Serious Acute Condition" is

- a disease or condition requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy.

Continuity of care will end when the earliest for the following conditions have been met:

- upon successful transition of care to a Participating Provider
- upon completion of the course of treatment prior to completion of the 6th month of continuity of care
- upon completion of the 6th month of continuity of care
- if You have met or exceeded the benefit limits under Your plan
- if care is not Medically Necessary
- if care is excluded from your coverage
- if you become ineligible for coverage

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to the lesser of Molina's Allowed Amount or the agreed-upon rate for such services.

Transition of Care

If You are new to Molina, We may allow You to continue receiving Covered Services for an ongoing course of treatment with a Non-Participating Provider until we arrange transition of care to a Participating Provider, under the following conditions:

1. Molina will only extend coverage for Covered Services to Non-Participating Providers, when it is determined to be Medically Necessary, through Our Prior Authorization review process. You may contact Molina to initiate Prior Authorization review.

2. Molina provides Covered Services on or after Your effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina), may be responsible for coverage until Your coverage is effective with Molina.

3. After Your effective date with Molina, We may coordinate the provision of Covered Services with any Non-Participating Provider (physician or hospital) on Your behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

For Inpatient Hospital Services:

- With Your assistance, Molina may reach out to any prior insurer (if applicable) to determine Your prior insurer's responsibility for payment of inpatient hospital services through discharge of any inpatient admission. If there is no transition of care provision through Your prior insurer or You did not have coverage through an insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of Your coverage with Molina, not prior.

24-Hour Nurse Advice Line

If You have questions or concerns about Your health or Your family's health, call Our 24-Hour Nurse Advice Line.

English: 1 (888) 275-8750
Spanish: 1 (866) 648-3537
TTY: 711

The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

What If There Is No Participating Provider to Provide a Covered Service?

If there is no Participating Provider that can provide a non-Emergency Covered Service, You may request Prior Authorization to obtain the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the same Covered Services when rendered by Participating Providers.

When You utilize a hospital or an ambulatory surgery center which is a Participating Provider, and, due to any reason, a Participating Provider for radiology, anesthesiology, pathology, emergency physician, or neonatology is unavailable and Covered Services are provided by a Non-Participating Provider, the same Cost-Sharing will apply as if the Covered Services were provided by a Participating Provider.

Referrals

A Referral is a recommendation from Your PCP for You to visit a Specialist Physician or receive certain healthcare services. Your PCP and Specialist Physician will determine the care You need and coordinate services as appropriate. Your PCP will issue You a Referral by contacting Molina directly prior to Your visit.

Your Specialist Physician may discuss further testing and other services with Your PCP after Your visit. Tests and services not included in the Referral or performed outside the Specialist Physician's office may require a separate authorization.

You will need a Referral from Your PCP to see a Specialist Physician; however, You can see the following specialties without a Referral from Your PCP:

- Podiatry
- Chiropractic
- Dermatology (first 5 visits)
- Obstetrician and gynecologist (OB/GYN)

Second Opinions

You or Your PCP may want another doctor (a PCP or Specialist Physician) 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.

Here are some, but not all, 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.

Second Opinions From Non-Participating Providers

You may obtain a second opinion from the provider of Your choice, including from a Non-Participating Provider, for the following reasons:

- You dispute Molina's or a physician's opinion of the reasonableness or necessity of surgical procedures.
- You are seriously injured or ill.

If You choose a physician that is a Non-Participating Provider, then Molina will pay the amount of all charges that are usual, reasonable, and customary in the community, and You will be responsible for a coinsurance payment in the amount of 40%.

The Non-Participating Provider must be in the Molina Service Area for this product, unless Molina gives Prior Authorization for another provider.

For tests that are deemed necessary by the physician, Molina may require the tests to be conducted by Participating Provider test facilities.

You may be limited to three second-opinion requests per calendar year under this product.

What is a Prior Authorization?

A **Prior Authorization** is an approval from Molina for a requested health care service, treatment plan, prescription drug or durable medical equipment. A Prior Authorization confirms that the requested service or item is Medically Necessary and is covered under Your plan. Molina's Medical Director and Your doctor work together to determine the Medical Necessity of Covered Services before the care or service is given. This is sometimes also called prior approval.

You do not need Prior Authorization for the following services when Covered Services are provided by Participating Providers:

- Dermatological Services (up to 5 office visits per year without Prior Authorization)
- Dialysis (notification only, Prior Authorization is not required)
- Family planning services
- The following rehabilitative services
  - Cardiac therapy
  - Pulmonary therapy
  - Spinal Manipulative Therapy when performed by a Chiropractor
- Human Immunodeficiency Virus (HIV) testing and counseling
- The following mental health services:
  - Individual and group mental health evaluation and treatment
  - Evaluation of Mental Disorders
  - Outpatient services for the purposes of drug therapy
  - Intensive Outpatient Programs (IOP)
- The following substance abuse services:
  - Individual and group substance abuse counseling
  - Medical treatment for withdrawal symptoms

    - Individual substance abuse evaluation and treatment
    - Group substance abuse treatment,
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- Pregnancy and delivery (notification only, Prior Authorization is not required)
- Podiatry Services
- Routine diagnostic imaging (such as x-rays, mammograms and ultrasound)
- Services for sexually transmitted diseases
- Spinal Manipulation Therapy

You must get Prior Authorization for the following services, among others. This is not an all-inclusive list. This does not apply to Emergency Services or Urgent Care Services, except as indicated below.

- Certain Ambulatory Surgery Center service (ASC)*
- Certain drugs as indicated on the published Drug Formulary*
- Certain Durable Medical Equipment*
- Certain habilitative services
- Certain injectable drugs and medications not listed on the Molina Drug Formulary
- Mental Health Services
    - Day treatment
    - Electroconvulsive Therapy (ECT)
    - Mental health inpatient
    - Neuropsychological and psychological testing
    - Partial hospitalization
    - Behavioral health treatment for PDD/autism
- Substance Abuse Services:
    - Inpatient services
    - Partial hospitalization
    - Day Treatment
    - Detoxification Services
- Certain outpatient hospital service*
- Cosmetic, plastic, and reconstructive procedures
- Custom orthotics, prosthetics, and braces. Examples are:
    - Any kind of wheelchairs (manual or electric)
    - Internally implanted hearing device
    - Scooters
    - Shoes or shoe supports
    - Special braces
- Drug quantities that exceed the day-supply limit
- Experimental or Investigational procedures
- Home health care and home infusion therapy (after initial evaluation, plus 6 visits for home settings)
- Hospice care (inpatient and outpatient)
- Hyperbaric therapy
- Specialized scanning services such as:
    - CT (Computed Tomography)
    - MRI (Magnetic Resonance Imaging)
    - MRA (Magnetic Resonance Angiogram)

    - PET (Positron Emission Tomography) scan
- Inpatient admissions
- Low vision follow-up care
- Medically Necessary genetic testing
- Observation stays
- Pain management services and procedures
- Prescription drug refills prescribed by Non-Participating Providers
- Radiation therapy and radio surgery
- The following Rehabilitative services in outpatient and home settings:
    - Occupational Therapy (after initial evaluation)
    - Physical Therapy (after initial evaluation)
    - Speech Therapy (after initial evaluation)
    - Massage Therapy
- Services rendered by a Non-Participating Provider, including Urgent Care Services
- Sleep studies (except home sleep studies)
- Specialty drugs (oral and injectable)
- Transplant evaluation and related services including Solid Organ and Bone Marrow (Cornea transplant does not require authorization)
- Non-emergency air ambulance
- Any other services listed as requiring Prior Authorization in this Agreement

*Call Our Customer Support Center at 1 (888) 560-5716. You can find out if Your service needs Prior Authorization.

Molina may deny 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.

Prior Authorization decisions and notifications for medications not listed on the Molina Drug Formulary will be provided as described in the section of this Agreement titled "Access to Drugs That Are Not Covered."

Approvals are given based on Medical Necessity. You or Your Participating Provider may call for Prior Authorization; however, You are ultimately responsible for requesting the Prior Authorization. If You have questions about how a certain service is approved, call Us toll-free at 1 (888) 560-5716. Hearing-impaired Members may call Us via TTY at 1 (800) 955-8771 or dial 711.

Upon request, We will be happy to send You a general explanation of how Prior Authorization decisions are made.

Request Types	Time Frame for Decision
Pre-Service Authorization	• Decision within 15 days of receipt of the request for services • Molina may extend the 15-day period for an additional 15 days due to matters beyond Molina's control • If an extension 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	• Decision within 72 hours of receipt of the request for authorization of Urgent Care Services • For other types of requests, a decision will be made within 15 days
Post-Service Authorization	• Decision 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. This is 72 hours from receipt of all information reasonably necessary and requested by Molina to make the determination. We will deny a Prior Authorization if information We request is not provided to Us. The time required may be shorter under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina 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 in the section of this Agreement titled "Appeals."

Standing Approvals

If You require Prior Authorization for a condition or disease that requires specialized medical care over a prolonged period, You may need a standing approval. If You receive a standing approval, You will not need to get a Prior Authorization every time You obtain Covered Services.

If Your condition or disease is life threatening, worsening, or disabling, You may need a standing approval to a specialty care center. They have the expertise to treat Your condition or disease.

To get a standing approval, call Your PCP. Your PCP will work with Molina's physicians and Specialist Physicians to ensure You receive a treatment plan based on Your medical needs.

If You have any difficulty getting a standing approval, call Us toll-free at 1 (888) 560-5716. Hearing-impaired Members may call Us via TTY at 1 (800) 955-8771, or call 711.

If You feel Your needs have not been met, please refer to Our complaint process in the section of this Agreement titled "Complaints."

EMERGENCY SERVICES AND URGENT CARE SERVICES

What is an Emergency?

"Emergency Services" means health care services needed to evaluate, stabilize, or treat an Emergency Medical Condition. An "Emergency Medical Condition" includes a medical or psychiatric medical condition having acute and severe symptoms. This could include severe pain or 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. Services provided within an emergency room that do not meet the definition of Emergency Services are considered non-emergent and will be not covered.

How do I get Emergency Services?

Emergency Services are available 24 hours a day, seven days a week for Molina 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 Services, bring Your Molina Member ID card with You.

If You are not sure if You need Emergency Services but You need medical help, call Your PCP. You can also call Our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish, You may dial 1 (866) 648-3537. If You are deaf or hard of hearing, please use the Telecommunications Relay Service by dialing 711.

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.

Hospital emergency rooms are only for real Emergencies. These are not good places to get non-Emergency Services. 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 am away from Molina's Service Area and in need of Emergency Services?

Go to the nearest emergency room for care.

Please contact Molina within 24 hours of getting Emergency health care, or when medically reasonable. Call toll-free at 1 (888) 560-5716. If You are deaf or hard of hearing, call Us via TTY at 1 (800) 955-8771 or dial 711 for the Telecommunications Relay Service. When You are away from Molina's Service Area, only Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?

Urgent Care Services are available from Participating Providers when You are within Molina's Service Area. Urgent Care Services are those health care 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, call Your PCP.

You may also call Our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish, call 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 treated.

If You are within Molina'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's Service Area, You may call Your PCP or call Our 24-hour Nurse Advice Line at 1 (888) 275-8750 or go to the nearest emergency room. Out-of-area urgent care centers are covered only with Prior Authorization.

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Please be aware that if You go to a Non-Participating Provider, they may balance-bill You for the difference between Our allowed amount and the rate they charge. You will be responsible for charges that exceed the allowed amount covered by Us.

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

Living with and managing health problems can be hard. Molina has a program that can help.

The Complex Case Management program is for Members who need extra help with their difficult health care problems and 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. If You are deaf or hard of hearing, You may contact Us via TTY at 1 (800) 955-8771. You may also dial 711 for the Telecommunications Relay Service.

Pregnancy - What if I am pregnant?

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

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 Us toll-free at 1 (888) 560-5716. We are available Monday through Friday from 8:00 a.m. to 7:00 p.m. ET. We are happy to assist You.

ACCESSING CARE FOR MEMBERS WITH DISABILITIES

Americans with Disabilities Act

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

Physical Access

Molina has made every effort to ensure that Our offices and the offices of Our doctors are accessible to persons with disabilities.

If You are not able to locate a doctor who meets Your needs, please call Us toll-free at 1 (888) 560-5716. If You are deaf or hard of hearing, You may contact Us via TTY at 1 (800) 955-8771. A Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing

Call Our Customer Support Center through Our TTY Number toll-free at 1 (800) 955-8771. You may also dial 711 for the Telecommunications Relay Service.

Access for Persons with Low Vision or who are Blind

This Agreement and other important product 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. 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 Us 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 Our Customer Support Center.

Disability Access Grievances

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

COVERED SERVICES

Molina covers the services described in the section titled "What is Covered Under My Plan?" below. These are subject to the exclusions, limitations, and reductions set forth in this Agreement. They are covered 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; however:
    - You may receive Covered Services from providers outside the Service Area where specifically noted in this Agreement. An example is if You are in need of Emergency Services.
    - You may receive Covered Services from Non-Participating Providers where specifically noted in this Agreement. An example is if You receive a second opinion as described in the section of this Agreement titled "Second Opinions From Non-Participating Providers."

The only services Molina covers under this Agreement are those described in this Agreement. They are 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, and/or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You are required to pay for each type of Covered Service is listed in the Schedule of Benefits at the beginning of this Agreement.

You must pay Cost Sharing for Covered Services. An exception is 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 Schedule of Benefits 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 SCHEDULE OF BENEFITS CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING IS.

Annual Out-of-Pocket Maximum

Also referred to as **"OOPM,"** this is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1) the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
2) the family OOPM will be met when Your family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your 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 has negotiated with the Participating Provider.

Coinsurances are listed in the Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible and/or Copayment.

Copayment

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

Deductible

The Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina 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 has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Agreement.

Please refer to the Schedule of Benefits 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 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. However, for preventive services covered by this Agreement and included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services when provided by a Participating Provider.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

- when You meet the Deductible for the individual Member; or
- when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible.

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing unless specifically stated or until You pay the applicable Annual Out-of-Pocket Maximum. Please refer to the Schedule of Benefits at the beginning of this Agreement for Cost Sharing amounts You will be required to pay for Covered Services.

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. This is as long as the services are covered under Your prior health plan Evidence of Coverage, and there has been no break in coverage.

  If the services are not covered under Your prior health plan Evidence 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. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Receiving a Bill

In many 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. 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 that are not Covered Services under this EOC, which may include charges for any health care services provided by a Non-Participating Provider.

How Your Coverage Satisfies the Affordable Care Act

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

Your EHB 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. However, You will not be eligible for pediatric services under this Agreement if You are 26 years of age or older, or 30 years of age or older as determined by Florida law. This includes pediatric dental that can be separately purchased through the Marketplace and pediatric vision.

The Affordable Care Act provides certain rules for EHB. These rules tell Molina how to administer certain benefits and Cost Sharing 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.

Molina must ensure that the Cost Sharing that You pay for all EHB 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 that a Member is required to pay to receive EHB. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments, and/or similar charges. Cost Sharing does not include 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
    - Tax credits may reduce Your Premiums and/or Your Cost Sharing responsibility toward the EHB
- To assist You in determining whether You are a qualifying American Indian or Alaskan Native
    - Qualifying American Indians and Alaskan Natives may have limited or no Cost Sharing responsibilities for EHB
- For information about any annual limits on Cost Sharing towards Your EHB

Molina will work with the Marketplace to help You. We do not determine or provide Affordable Care Act tax credits.

Emergency Services Rendered by a Non-Participating Provider

Emergency Services obtained for treatment of an Emergency Medical Condition are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits. We cover Emergency Services whether received from Participating Providers or Non-Participating Providers.

Important: Except as otherwise required by state law, when You receive Emergency Services from Non-Participating Providers (which may include, but are not limited to, emergency room providers, radiologists, anesthesiologists, or pathologists) for the treatment of an Emergency Medical Condition, Molina will calculate the allowed amount as the greatest of the following:

1) Molina's Allowed Amount for such services,
2) Molina's median contracted rate for such services, or
3) 100% of Medicare rate for such services.

Molina will calculate the amount paid to the Non-Participating Provider as the lesser of either the Non-Participating Provider's billed charges or Molina's allowed amount, in compliance with state law.

Services of Specified Non-Contracted Hospital-Based Physician

In the event You receive non-emergency care from a hospital-based Non-Participating Provider who is delivering services in a Participating Provider hospital, the care must be:

- Medically Necessary
- Prior Authorized
- A Covered Service

The Non-Participating Providers delivering services in a Participating Provider hospital may include, but are not limited to, pathologists, radiologists, and anesthesiologists.

Molina will reimburse the Non-Participating Provider for these services at Our Allowed Amount. You will be responsible for any applicable Deductible and/or Coinsurance for inpatient and/or outpatient professional services described in the Schedule of Benefits. Because Non-Participating Providers are not in Molina's contracted provider network, they may balance-bill You for the difference between Our Allowed Amount and the rate that they charge. In addition, any payment for the amounts that exceed Our Allowed Amount will not be applied to Your Deductible or Your Annual Out-of-Pocket Maximum.

WHAT IS COVERED UNDER MY PLAN?

This section tells You what medical services Molina covers, also known as Your 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. For information on how You can have Your case reviewed, see the "Complaints and Appeals" section.

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Refer to the section titled "What is a Prior Authorization?" for more information.

Molina also may cover routine medical costs for Members in Approved Clinical Trials. Refer to the section titled "Approved Clinical Trials" to find out more.

Covered Services may be provided by Other Practitioners contracted with Molina within the scope of their license. Other Practitioners may include a range of healthcare professionals, including without limitation:

- Advanced Registered Nurse practitioners
- Audiologists
- Certified Registered Nurse anesthetists
- Chiropractors
- Clinical Psychologists
- Dentists
- Mental health counselors
- Midwives
- Nurses
- Nurse midwives
- Nutritionists
- Ophthalmologists
- Optometrists
- Osteopaths
- Pharmacists
- Physical therapists
- Physicians
- Physician assistants
- Podiatrists
- Social workers
- Speech therapists

Other Practitioners may also include other professionals engaged in the delivery of health services who are:

- Licensed
- Certified
- Practice under:
  - An institutional license, or
  - 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 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 that require Prior Authorization, refer to the section titled "What is a Prior Authorization?"

Prior Authorization does not apply to treatment of Emergency Services or 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. Please consult with Your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for the following when provided by a Participating Provider:

- 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, preventive care services and screenings 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.

Coverage will start for product years that 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. These coverage limits are consistent with the Affordable Care Act and applicable Florida law. These coverage limits are also applicable to the preventive care benefits listed below.

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

Preventive Services for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents through age 18. You will not pay any Cost Sharing if services are furnished by a Participating Provider.

- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services to include:

    - Perinatal and postpartum care
    - Health education
    - Nutrition assessment
    - Psychological services
- Autism screening for children 18-24 months Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Behavioral health assessment for children
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services:
    - Covered for Members under the age of 21, including those with special health care needs
    - Includes EPSDT services provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management
- Hearing screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*****
- Iron supplementation in children when prescribed by a Participating Provider
- 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
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 10 to 24)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

*****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 or 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. This includes seniors. You will not pay any Cost Sharing if preventive care services are furnished by a Participating Provider:

- Abdominal aortic aneurysm screening: for male former smokers age 65-75
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA counseling about breast cancer preventive medication
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies counseling
- Cancer screening
- Cholesterol check
- Chlamydial infection screening: women
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk.)
- Depression screening: adults
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Dietary evaluation and nutritional counseling
- Exercise of physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations

- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention
- Osteoporosis screening for women (based on Your age)
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 10 to 24)
- Statin preventive medication: adults age 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions
    - Screening for tobacco use; and,
    - For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
- Tuberculosis (TB) screening
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

A baseline mammogram will be provided for any woman who is 35 years of age or older but younger than 40 years of age.

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

- 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
- 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
    - Of having a history of biopsy-proven benign breast disease
    - Of having a mother, sister, or daughter who has had breast cancer
    - A woman has not given birth before the age of 30s

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. If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) for routine examinations and prenatal care.

- Prevention, diagnosis, and treatment of illness or injury
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist Physician (for example, a heart doctor or cancer doctor) consultations
- 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
- 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
- Drugs administered by PCPs, Specialist Physicians and Other Practitioners, for example:

    - Medical self-administered drugs in the treatment of cancer, diabetes or conditions requiring immediate stabilization or administration of dialysis services related to diabetes (dialysis Cost Sharing is listed in the Schedule of Benefits)

- Treatment of osteoporosis for a Medically Necessary diagnosis
- Treatment of osteoporosis for high-risk individuals. High risk individuals includes, but is not limited to, those who:

    - Are estrogen-deficient and at clinical risk for osteoporosis
    - Have vertebral abnormalities
    - Are receiving long-term glucocorticoid (steroid) therapy
    - Have primary hyperparathyroidism
    - Have a family history of osteoporosis

- Child health supervision services for Dependent children from birth to 16 years of age that:

    - Are physician-delivered or physician-supervised services
    - May include, at a minimum, services delivered at the intervals and scope required by law
    - Must include periodic visits that include:

        - A history
        - A physical examination
        - A developmental assessment and anticipatory guidance

- Appropriate immunizations and laboratory tests

Such services and periodic visits must be limited to those that are required by the prevailing medical standards. Such services and periodic visits must be 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 (Refer to the Habilitative section for limits.)
- Audiology
- Nutrition services

Copayments for outpatient professional services listed in the Schedule of Benefits apply to services for cleft lip and cleft palate.

You or Your PCP may request Prior Authorization for treatment to be provided by a Non-Participating Provider who is a dentist or orthodontist.

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 Schedule of Benefits apply to dermatological services.

HABILITATIVE SERVICES

Medically Necessary habilitative services and devices are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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 living usually requiring physical therapy, speech therapy and occupational therapy in a setting appropriate for the level of disability or injury.

Outpatient rehabilitative services are limited to a total of 35 visits for any combination of the following therapies; however, only 26 of those visits can be for Spinal Manipulative Therapy.

- Cardiac Rehabilitation Therapy
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Massage Therapy by licensed massage therapist
- Spinal Manipulative Therapy

Prior Authorization is required after the initial evaluation for Occupational Therapy, Physical Therapy and Speech Therapy, and for all Massage Therapy

OUTPATIENT MENTAL/BEHAVIORAL HEALTH SERVICES

We cover the following outpatient mental health services 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 (defined below)
- Outpatient services for monitoring drug therapy

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). The "Mental Disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

We cover outpatient mental and behavioral health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of "Mental Disorders."

"Mental Disorders" include the Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following Mental Disorders:

- Anorexia nervosa
- Bipolar disorder (manic-depressive illness)
- Bulimia nervosa
- Major depressive disorders
- Obsessive-compulsive disorder
- Panic disorder
- Schizophrenia
- Schizoaffective disorder

To find a mental health Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.

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.

To find a substance abuse Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.

DIABETES MANAGEMENT SERVICES

We cover the following diabetes management services. We cover them only when the treating PCP or other Participating Provider physician who specializes in the treatment of diabetes certifies that such services are Medically Necessary:

- Outpatient self-management training and educational services
- Nutritional counseling
- Equipment and supplies used to treat diabetes
- Diabetic eye examinations (dilated retinal examinations)

Covered Services also may include routine foot care. Routine foot care for the treatment of diabetic foot disease may include:

- Trimming of toenails, corns, calluses
- Therapeutic shoes, including inserts and/or modifications

Copayments for outpatient professional services listed in the Schedule of Benefits 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 cover some dental and orthodontic services only as described in this "Dental and Orthodontic Services" section.

Dental Services for Radiation Treatment

We cover the following services to prepare Your jaw for radiation therapy of cancer in Your head or neck:

- Dental evaluation
- X-rays
- Fluoride treatment
- Extractions

We cover these dental services for radiation treatment when:

- Medically Necessary
- Provided by a:

    - Participating Provider; or
    - A Non-Participating Provider who is a dentist, only when Molina gives Prior Authorization

Dental Anesthesia

For Medically Necessary dental procedures, We cover general anesthesia. We also cover the Participating Provider facility's services associated with the anesthesia. We cover these for a Member who:

- Is under age eight and 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

- 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.

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

We do not cover dental implants.

Dental Services Related to Accidental Injury

We cover services for dental work that are to repair sound natural teeth for an injury that is caused by a sudden, unintentional, and unexpected event or force. We cover these services 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
- Orthodontic services

We cover these 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
- The services are provided by a:

    - Participating Provider; or
    - A dentist or orthodontist who is a Non-Participating Provider but to whom Molina has provided Prior Authorization

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, 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 Schedule of Benefits 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 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.

VISION SERVICES

We cover the following vision services for all Members:

- Diabetic eye examinations (dilated retinal examinations)
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye

Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision Services."

PEDIATRIC VISION SERVICES

We cover the following vision services for Members under the age of 26, or under the age of 30 as determined by Florida law:

- Routine vision screening and eye exam every calendar year

- Prescription glasses (frames and lenses) - limited to one pair of prescription glasses once every 12 months to include:
  - Limited selection of covered frames
    - Participating Providers will show the limited selection of covered frames available to You under this product
    - Frames that are not within the limited selection of covered frames under this product are not covered
  - Prescription lenses include:
    - Single vision
    - Lined bifocal
    - Lined trifocal
    - Lenticular lenses
    - Polycarbonate lenses
    - Scratch resistant coating and UV protection

- Prescription contact lenses, in lieu of prescription lenses and frames:
  - Limited to one pair of standard lenses every calendar year
  - Includes evaluation, fitting and follow-up care

  Prescription contact lenses are also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:
  - Aniridia
  - Aniseikonia
  - Anisometropia
  - Aphakia
  - Corneal disorders
  - Irregular astigmatism
  - Keratoconus
  - Pathological myopia
  - Post-traumatic disorders

- Low vision optical devices including:
  - Low vision services
  - Training and instruction to maximize remaining usable vision
  - Follow-up care when services are Medically Necessary and Prior Authorization is obtained

  With Prior Authorization, low vision optical device coverage includes:
  - One comprehensive low vision evaluation every five years
  - High-power spectacles, magnifiers, and telescopes as Medically Necessary
  - 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 PCPs and OB/GYN Specialist Physicians are available for family planning services.

You can make an appointment without having to get Prior Authorization from Molina. Molina pays the doctor or clinic for the family planning services You receive.

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
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- 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 Participating Provider pharmacist, or by a Non-Participating 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

Family planning services do not include:

- Condoms for male use, as excluded under the Affordable Care Act

PREGNANCY TERMINATION

To the extent permitted by state and federal law, Molina only covers pregnancy termination services in the following instances:

- If the Member's pregnancy is the result of an act of rape or incest;
- In the case where the Member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a Participating Provider, place the Member in danger of death unless a pregnancy termination is performed.

Pregnancy termination services, when provided in an office, do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital setting, 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

Enteral formulas are used to treat the following:

- Inherited diseases related to the metabolism of amino acids, organic acids, carbohydrates or fat
- Malabsorption originating from congenital defects present at birth or acquired during the neonatal period

Durable Medical Equipment (DME) Cost Sharing will apply.

OUTPATIENT HOSPITAL/FACILITY SERVICES

OUTPATIENT SURGERY

We cover outpatient surgery services provided by Participating Providers if they are 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. We cover these services 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 covers chemotherapy drugs and related services when prescribed and administered by Participating Providers. The prescription drug Cost Sharing 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. Prior Authorization is required. Hospital locations are covered for Emergency Services, observation stay, or during an inpatient hospital admission. Molina will help you select an appropriate facility.

RADIOLOGY SERVICES (e.g., X-Rays)

We cover X-rays and radiology services, other than specialized scanning services. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

Chemotherapy and Other Provider-Administered Drugs
We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

LABORATORY TESTS

We cover the following services when Medically Necessary. These services are subject to Cost Sharing. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

- 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 a 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

To find a mental health Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services, except in the case of an Emergency. If You get services in a hospital or You are admitted to the hospital for Emergency Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services provided in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

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 Specialist Physicians, 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 Drug Coverage" 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

Chemotherapy and Other Provider-Administered Drugs
We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility Cost Sharing.

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). A longer inpatient stay for You and Your newborn requires that You or Your provider notifies Molina.. Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Schedule of Benefits for the Cost Sharing that will apply to these services

- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48- or 96-hour period, Molina 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 and drugs. Coverage also includes services of Participating Provider physicians and other Participating Providers who are licensed health care professionals acting within the scope of their license.

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). The "Mental Disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

We cover inpatient hospital mental or behavioral health services, including services for the treatment of gender dysphoria, only when the Member has a "Mental Disorder."

"Mental Disorders" include the Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders:

- Anorexia nervosa
- Bipolar disorder (manic-depressive illness)

- Bulimia nervosa
- Major depressive disorders
- Obsessive-compulsive disorder
- Panic disorder
- Schizophrenia
- Schizoaffective disorder

To find a mental health Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.

SUBSTANCE ABUSE DISORDER: INPATIENT DETOXIFICATION

We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of its withdrawal symptoms. Coverage includes:

- Room and board
- Participating Provider physician services
- Drugs
- Dependency recovery services
- Education
- 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. These settings provide counseling and support services in a structured environment.

To find a substance abuse Participating Provider, contact **Beacon Health** at **1 (800) 221-5487**.

SKILLED NURSING FACILITY

We cover skilled nursing facility (SNF) services when Medically Necessary. 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 Sharing will apply to chemotherapy drugs)
- Physical, speech, and occupational therapies

You must have Prior Authorization for these services before the service begins. 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

- Dietician services
- 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 care 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
  - These therapies are covered:
    - 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 Members who are diagnosed with a terminal illness. A terminal illness means that life expectancy is 12 months or less.

You can choose hospice care instead of the traditional services covered by this product. You may discuss the options with Your provider. No Prior Authorization is required.

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 for coverage in this product
- Be diagnosed with cancer or other life threatening disease or condition
- Be accepted into an approved clinical trial (as defined below)
- Have received Prior Authorization or approval from Molina.
  - 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 one of the following three statements is true:

(1) The study is approved or funded by one or more of the following:

- National Institutes of Health
- Centers for Disease Control and Prevention
- Agency for Health Care Research and Quality
- Centers for Medicare and Medicaid Services
- U.S. Department of Defense

- U.S. Department of Veterans Affairs
- U.S. Department of Energy

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(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 were not specifically related to an approved clinical trial. 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 Schedule of Benefits.

Molina does not have an obligation to cover certain items and services that are not routine patient costs as determined by the Affordable Care Act. This applies even when You incur these costs while in an approved clinical trial. Costs that are not covered 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
- Any service inconsistent with the established standard of care for the patient's diagnosis

All approvals and Prior 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 or Your PCP for further information.

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
    - Disease

Reconstructive surgeries due to the above causes are covered if a Participating Provider physician determines that they are 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 covers:

    - Reconstruction of the breast
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - 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 were not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

Please refer to the "Exclusions" section of this Agreement for a description of exceptions that apply for reconstructive surgery.

TRANSPLANT SERVICES

We cover transplants of the following organs and tissue at participating transplant facilities. We cover these transplants if Molina provides Prior Authorization, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

- Cornea
- Heart
- Lung
- Liver
- Kidney
- Pancreas
- Bone Marrow

    - We cover 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 Agreement, 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 life prolonging intent.

    - Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor. Human blood precursor cells 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.

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

After the Prior Authorization for the services of a transplant facility, the following applies:

- If either the physician or the transplant facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that determination is made
- Molina 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 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 were not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

Molina 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 prescription drug is listed in the Molina Drug Formulary or has been approved by Our Pharmacy Department
- They are ordered or given while You are in an emergency room or hospital
- They are given while You are in a skilled nursing facility
  - The prescription drug or medication must be ordered by a Participating Provider in connection with a Covered Service
  - The prescription drug or medication must be filled through a pharmacy that is in the Molina pharmacy network
- The prescription 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 prescription drugs and medications at a plan contracted retail pharmacy unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy.

Please note, Cost Sharing reduction for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third-party Cost Sharing assistance, will not apply toward any Deductible or the Annual Out-of-Pocket Maximum under Your Plan.

We cover:

- Tier-1: Lower-Cost Generic and Brand Name Drugs,
- Tier-2: Preferred Generic and Brand Name Drugs,
- Tier-3: Non-Preferred Brand Name Drugs,
- Tier-4: Generic and Brand Name Specialty Drugs, and
- Tier-5: Preventive Drugs.

We cover drugs when they are on the Drug Formulary. We cover drugs when obtained through Molina's Participating Provider pharmacies within the Service Area. Non-formulary drugs may be covered only as provided in the "Access to Drugs That Are Not Covered" section below.

Prescription drugs are covered outside of the Service Area for Emergency Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Our Customer Support Center toll-free at 1 (888) 560-5716 for assistance. If You are deaf or hard of hearing, call Us via TTY at 1 (800) 955-8771 or contact Us with the Telecommunications Relay Service by dialing 711.

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

Molina Drug Formulary (List of Drugs)

Molina has a list of drugs that We will cover. The list is known as the Drug Formulary.

The drugs on the Drug Formulary are chosen by a group of doctors and pharmacists from Molina and the medical community. The group meets every 3 months to talk about the drugs that are on the Drug Formulary.

The group reviews new drugs and changes in health care to find the most effective drugs for different conditions. Drugs are added to or removed from the Drug Formulary based on changes in medical practice, medical technology, and when new drugs come on the market.

Formulary generic drugs are those drugs listed in the Molina Drug Formulary that have the same ingredients as brand name drugs. To be FDA (government) approved, a 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.

Formulary brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their 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 and Our pharmacy benefit manager.

You can look at Our Drug Formulary on Our Molina website at MolinaMarketplace.com.

You may call Us 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 Telecommunications 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.

Cost Sharing for Prescription Drugs and Medications

The Cost Sharing for prescription drugs and medications is listed on the Schedule of Benefits. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis.

The exception is when such drug therapy is an EHB preventive care prescription drug administered or prescribed by a Participating Provider. In this case, the EHB preventive care prescription drug is not subject to Cost Sharing.

Tier-1: Lower-Cost Generic and Brand Name Drugs

Formulary drugs in this tier include lower-cost generic and brand name drugs. Specialty drugs are not included in this tier.

Lower-cost generic and brand name drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as “Tier-1” in the Molina Drug Formulary.

Tier-2: Preferred Generic and Brand Name Drugs

Formulary drugs in this tier include preferred generic and brand name drugs. Specialty drugs are not included in this tier.

Preferred generic and brand name drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as “Tier-2” in the Molina Drug Formulary. .

Tier-3: Non-Preferred Brand Name Drugs

Formulary drugs in this tier include non-preferred brand name drugs. Specialty drugs are not included in this tier.

Non-preferred brand name drugs are those drugs listed in the Molina Drug Formulary that are designated as “Tier-3” due to lesser clinical effectiveness and cost differences. Generally, there are preferred and often less costly therapeutic alternatives at a lower tier.

Tier-4: Generic and Brand Name Specialty Drugs

Formulary drugs in this tier include both generic and brand name specialty drugs, including biosimilars.

Specialty drugs are prescription legend drugs within the Molina Drug Formulary that:

- 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; or
- A biosimilar, a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

Molina requires Prior Authorization for specialty drugs. We may require that Specialty drugs be obtained from a Participating Provider specialty pharmacy or facility for coverage. Molina's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office.

Tier-5: Preventive Drugs

Formulary Preventive drugs are drugs listed in the Molina Drug Formulary that are considered to be used for preventive purposes, including all methods of birth control drugs or devices for women approved by the FDA, or if they are being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered. A drug is not considered preventive if it is being prescribed to treat an existing, symptomatic illness, injury, or condition. Formulary Preventive drugs may include Generic or Brand Name drugs.

Access to Drugs That Are Not Covered

Molina has a process to allow You to request and gain access to clinically appropriate drugs that are not covered under Your product.

Molina may cover specific non-formulary drugs when the prescriber documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

If Your doctor prescribes a drug that is not listed on the Drug Formulary, Your doctor must submit a Prior Authorization request to Molina's Pharmacy department.

- If You do not obtain a Prior Authorization from Molina, We will send a letter to You and Your doctor stating why the drug was denied. You may purchase the drug at the full cost charged by the pharmacy.
- If You obtain a Prior Authorization from Molina, We will contact Your doctor. You may purchase the drug at the Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs.

For substitution of a formulary generic drug with a non-formulary brand name drug, You may purchase the brand name drug at the following Cost Sharing:

- The Cost Sharing for Tier-3 for non-specialty drugs or Tier-4 for specialty drugs, plus
- The difference in cost between the formulary generic drug and brand name drug.

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.

There are two types of requests for clinically appropriate drugs that are not covered under Your product:

- **Expedited Exception Request** for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- **Standard Exception Request.**

You and/or Your Participating Provider will be notified of Our decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

If initial request is denied, You and/or Your Participating Provider may request an external review. You and/or Your Participating Provider will be notified of the external decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

Stop Smoking Drugs

We cover drugs to help You stop smoking. You will have no Cost Sharing for stop-smoking drugs.

You can learn more about Your stop-smoking options by calling Our Health Management Level 1 Programs Department toll-free at 1 (866) 472-9483 between 11:30 a.m. and 8:30 p.m. ET Monday through Friday.

Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop smoking medication.

Mail Order Availability of Formulary Prescription Drugs

Molina offers You a mail order Formulary Prescription drug option. Formulary Prescription drugs can be mailed to You within 10 days from order request and approval. Cost Sharing is a 90-day supply applied at two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one month.

You may request mail order service in the following ways:

- You can order online. Visit MolinaMarketplace.com and select the mail order option. Then follow the prompts.

- You can call the FastStart® toll-free number at 1 (800) 875-0867. Provide Your Molina Marketplace Member number (found on Your ID card), Your prescription name(s), Your doctor's name and phone number, and Your mailing address.
- You can mail a mail-order request form. Visit MolinaMarketplace.com and select the mail order form option. Complete and mail the form to the address on the form along with Your payment. You can give Your doctor's office the toll-free FastStart® physician number 1 (800) 378-5697 and ask Your doctor to call, fax, or electronically prescribe Your prescription. To speed up the process, Your doctor will need Your Molina Marketplace Member number (found on Your ID card), Your date of birth, and Your mailing address.

Diabetic Supplies

Diabetic supplies are covered. Covered diabetic supplies are:

- Insulin syringes
- Lancets and lancet puncture devices
- Blood glucose monitors
- Blood glucose test strips
- Urine test strips

Select pen delivery systems for the administration of insulin are also covered.

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 Authorization is obtained.

Over-the-Counter Preventive Drugs and Supplements

Over-the-counter drugs and supplements that are required by state and federal laws to be covered for preventive care are available at no charge when prescribed by a Participating Provider.

- Folic Acid for women planning or capable of pregnancy
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Iron Supplements for children age 6 to 12 months at increased risk for iron deficiency anemia
- Aspirin for adults for prevention of cardiovascular disease

Cancer Treatment – Off-Label Drugs

For the purposes of this "Cancer Treatment – Off-Label Drugs" section, the term "medical literature" means scientific studies published in a United States peer-reviewed national professional journal.

The term "standard 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.

Molina will cover drugs prescribed for the treatment of cancer only if the drug is recognized for treatment of the diagnosed cancer in a standard reference compendium or recommended in the medical literature.

The Cost Sharing for off-label drugs for cancer treatment will vary depending upon how the drug is administered. For example, the Prescription Drug Coverage Cost Sharing for outpatient administration of off-label drugs listed in the Schedule of Benefits applies. These are also subject to Prior Authorization for any drugs that are not listed on the Molina Drug Formulary.

Likewise, off-label drugs for cancer treatment administered in an inpatient setting are subject to the inpatient Cost Sharing listed in the Schedule of Benefits. These are also subject to Prior Authorization for any drugs that are not listed on the Molina Drug Formulary.

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

Molina will not exclude or deny coverage of a drug that 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.

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT*

If You need Durable Medical Equipment (DME), Molina will rent or purchase the equipment for You.

Prior Authorization from Molina is required for DME. The DME must be provided through a vendor that is contracted with Molina.

We cover reasonable repairs, maintenance, delivery and related supplies for DME. You may be responsible for repairs to DME if they are due to misuse or loss.

Covered DME includes (but is not limited to):

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

We cover the following DME and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

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

PROSTHETIC AND ORTHOTIC DEVICES

We 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 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). We also cover services to determine whether You need a prosthetic or orthotic device.

If We cover a replacement device, You will 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, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the Molina Health Care of Florida, Inc. Schedule of Benefits to see the Cost Sharing applicable to these devices.

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
  - 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

Durable Medical Equipment Cost Sharing will apply for external devices.

HOME HEALTHCARE

We cover these home healthcare services when Medically Necessary and approved by Molina:

- 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
- Medically Necessary medical appliances

Home healthcare 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 healthcare services must be consistent with a plan of treatment ordered under the supervision of a registered nurse.

The following home healthcare 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 60 visits per calendar year

You must have Prior Authorization for home health services after the first 7 visits.

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 medical transportation (ground and air ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary. These services are covered only when any other type of transport would put your health or safety at risk. Covered emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits, up to Molina's Allowed Amount. Please note: You may be responsible for provider charges that exceed Molina's Allowed Amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.

Non-Emergency Medical Transportation

We cover non-routine, non-emergency Medically Necessary transportation, such as van or ambulance transportation between hospitals. Prior Authorization may be required. Covered non-emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits for inpatient hospital services, up to Molina's Allowed Amount.

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 at 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

Copayments for dialysis services are listed in the Schedule of Benefits.

You or a Participating Provider should notify Molina before services are provided. (Prior Authorization is not required.)

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

Your Covered Services include Emergency Services while traveling outside of the Service Area. This includes travel that takes You outside of the United States.

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 for charges that You paid for Covered Services given to You by the Non-Participating Provider.

You are responsible for ensuring that claims and/or records of such services are appropriately translated. You are also responsible for ensuring the monetary exchange rate is clearly identified when submitting claims for services received outside the United States.

Medical records of treatment and services 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 before payment can be made.

Molina will calculate the allowed amount that will be covered for 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. The allowed amount 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.

Acupuncture

Acupuncture services are not covered.

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)
- Zygote intrafallopian transfer (ZIFT)

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.

Certain Exams and Services

The following are not covered unless a Participating Provider physician determines that the services are Medically Necessary. Physical exams and other services that are:

- Required for obtaining or maintaining employment or participation in employee programs
- Required for insurance or licensing

- On court order or required for parole or probation.

Certain Mental Health Exams and Services

The following are not covered. 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 intended primarily to change or maintain Your appearance are not covered. 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
    - 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) is not covered.

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 the following, are not covered:

- X-rays
- Appliances
- Implants
- Services provided by dentists or orthodontists
- Dental services following accidental injury to teeth
- 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.

Dietician

A service of a dietician is not a covered benefit. This exclusion does not apply to services under hospice care or for Covered Services described in the section titled, "Diabetes Management Services."

Disposable Supplies

Disposable supplies for home use, such as the following, are not covered:

- Bandages, gauze, tape
- Antiseptics
- Dressings
- Ace-type bandages
- 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 the following Durable Medical Equipment:

- Durable Medical Equipment that 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
- Hearing aids (other than internally implanted devices as described in the "Prosthetic and Orthotic Devices" section)
- 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
- Replacement of Durable Medical Equipment solely because it is old or used

Erectile Dysfunction Drugs

Coverage of erectile dysfunction drugs unless required by state law.

Experimental or Investigational Services

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

This exclusion does not apply to 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.

Gene Therapy
Molina does not cover gene therapy.

Hair Loss or Growth Treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered.

Intermediate Care

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

Infertility Services

Services related to the diagnosis and treatment of infertility are not covered.

Items and Services That are Not Health Care Items and Services

Molina 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) to correct refractive defects of the eye such as myopia, hyperopia, or astigmatism are not covered. This exception does not apply to 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.

Male Contraceptives

Condoms for male use are not covered, as excluded under the Affordable Care Act.

Oral Nutrition

Outpatient oral nutrition is not covered. Examples of oral nutrition are:

- Dietary or nutritional supplements
- Specialized formulas
- Supplements
- Herbal supplements
- Weight loss aids
- Formulas
- Food

This exclusion does not apply to formulas and special food products when prescribed in accordance with the “Enteral Formulas” section of this Agreement

Private Duty Nursing

Private duty nursing services are not covered.

Reconstructive Surgery

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

Residential Care

Care in a facility where You stay overnight is not covered; however, this exclusion does not apply when the overnight stay is part of covered care in any of the following:

- 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
- 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 are not covered except as described Diabetes Management Services section above.

Services Not Approved by the Federal Food and Drug Administration (FDA)

The following services not approved by the FDA are not covered:

- Drugs
- Supplements
- Tests
- Vaccines
- Devices
- Radioactive materials

Any other services that by law require federal FDA approval in order to be sold in the U.S. but are not approved by the FDA are not covered.

This exclusion applies to services provided anywhere, even outside the United States.

These exclusions do not apply to services covered under the following sections of the "What is Covered Under My Plan?" section of this Agreement:

- "Approved Clinical Trials"
- "Cancer Treatment – Off-Label Drugs" provisions in the "Prescription Drug Coverage" subsection

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

Services Performed by Unlicensed People

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

Services Provided Outside the United States (or Service Area)

Any services and supplies provided to a Member outside the United States or outside the Service Area if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered.

Routine care, preventive care, primary care, specialty care, urgent care and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area. Only Emergency Services are Covered Services outside the United States or outside the Service Area.

When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered.

Services Related to a Non-Covered Service

When a Service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to services Molina would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service.

For example, if You have a non-covered bariatric surgery or cosmetic surgery, Molina 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. Molina would cover any services that We would otherwise cover to treat that complication.

Sexual Dysfunction

Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medication is not covered unless required by state law.

Surrogacy

Services for anyone in connection with a surrogacy arrangement are 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.

Travel and Lodging Expenses

Most travel and lodging expenses are not covered. Molina may pay certain expenses that Molina preauthorizes in accordance with Molina's travel and lodging guidelines.

Molina's travel and lodging guidelines are available from Our Customer Support Center by calling toll free at 1 (888) 560-5716. If You are deaf or hard of hearing, You may contact Us via TTY at 1 (800) 955-8771. You may also dial 711 for the Telecommunications Relay Service.

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, if You are made whole for all other damages resulting from the wrongful act or omission before Molina is entitled to reimbursement, then You shall:

- Reimburse Molina for the reasonable cost of services paid by Molina 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 effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under the laws of the State of Florida, Inc.

Molina's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

Molina shall be entitled to payment, reimbursement, and subrogation (recovery of 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 including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina shall not furnish benefits under this Agreement that 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'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 will provide the benefits described in this Agreement until resolution of the dispute.

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

RENEWAL AND TERMINATION

How Does my Molina Coverage Renew?

Coverage shall be renewed on the first day of each month upon Molina's receipt of any prepaid Premiums due. Renewal is subject to Molina'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 Covered Services

Any change to this Agreement, including, but not limited to, changes in Premiums, 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. Molina shall not change Deductible, Copayment, Coinsurance or Annual Out-of-Pocket Maximum amounts during the plan year, except when required by state or federal law.

The above does not apply in the following circumstances:

- Molina does not determine or provide Affordable Care Act tax credits, so Molina does not provide 60 days' notice for changes to the advance payment of the premium tax credit.

When Will My Molina Membership End? (Termination of Covered Services)

The termination date of Your coverage is the first day You are not covered with Molina.

For example, if Your termination date is July 1, 2017, Your last minute of coverage was at 11:59 p.m. on June 30, 2017.

If Your coverage terminates for any reason, You must pay all Premium and Cost-Sharing amounts payable and owing related to Your coverage with Molina for the period prior to Your termination date.

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

Your membership with Molina will terminate if You:

- **No Longer Meet Eligibility Requirements**

  Coverage under this Policy will terminate if: You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina or the Marketplace. The Marketplace will send You notice of any eligibility determination.
  - **For Non-Age-Related loss of Eligibility,** 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.
  - **For a Dependent Child Reaching the Limiting Age of 26,** Coverage under this Policy, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the calendar year in which the Dependent Child reaches the limiting age of 26, unless the child meets specified criteria. See the sections titled "Age Limit for Children (Disabled Children)" and "Continued Eligibility of Certain Children Beyond the Limiting Age of 26" for more information.
  - **For a Member with Child-Only Coverage Reaching the Limiting Age,** that Member's Child-Only Coverage under this Agreement, will terminate at 11:59 p.m. on the last day of the calendar year in which the Member reaches the limiting age of 21. When Child-Only Coverage under this Agreement terminates because the Member has reached age 21, the Member may be eligible to enroll in other products offered by Molina through the Marketplace.

- **Request Disenrollment**

  If You decide to end Your membership and disenroll from Molina by notifying the Marketplace (1-800-318-2596) and/or Molina, then 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.

- **Change Marketplace Health Plans**

  You may decide to change from Molina to another health plan offered through the Marketplace in either situation below:

  - 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
  - When You seek to enroll a new Dependent

  In either case, Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Commit Fraud or Intentionally Misrepresent Material Fact**

  Your membership will terminate if You commit any act or practice that constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina. Some examples include:

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

If Molina terminates Your membership for any reason other than non-payment of Premium or loss of eligibility, You will be given a 45-day advance written notice prior to Your coverage being terminated.

If Molina 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.

Please note the following with regard to membership termination:

- **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 ceases to provide or arrange for the provision of health benefits for new or existing health care service in the individual market, Your membership will terminate. In this case, Molina will provide You with written notice at least 180 days prior to the date the coverage will be discontinued.

- **Withdrawal of Product:** If Molina withdraws Your product from the market, Your membership will terminate. In this case, Molina will provide You with written notice at least 90 days prior to the date the coverage will be discontinued.

- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina may terminate Your coverage as further described in the "Premium Notices/Termination for Non-Payment of Premiums" section below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 26, or 30 as determined by Florida law, will no longer be eligible for Pediatric Vision Services covered under this Agreement. As a result, such Member's coverage under those specific Covered Services will terminate on his or her 26th birthday, or 30th birthday as determined by state law, without affecting the remainder of this Agreement.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Enter Your monthly Premium rate here: _____ The rate of payment entered above is a part of this contract in accordance with 641.31(6), F.S.

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 date stated on Your Premium bill. This is the "**Due Date.**"
    - Molina will send You a bill in advance of the Due Date for the upcoming coverage month.
    - If Molina does not receive the full Premium payment due on or before the Due Date, We will send a notice of non-receipt of Premium payment and termination of coverage (the "**Late Notice**") to the Your address of record.
    - This Late Notice will include, among other information, the following:
        - A statement that Molina 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 Your membership and the membership of any enrolled Dependents will end if We do not receive the required Premiums

If You have received a Late Notice that Your coverage is being terminated or not renewed due to failure to pay Your Premium, Molina will give a:

- 10-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit. Molina will process payment for Covered Services received during the 10-day grace period. You will be responsible for any unpaid Premiums You owe Molina for the grace period; or
- Three month grace period to pay the full Premium payment due if You receive advance payment of the premium tax credit. Molina will process payment for Covered Services received after the first month of the grace period so long as Your Premiums are paid in full before the end of the grace period.

If We do not receive Premiums by the end of the three-month grace period, You will be responsible for payment of the Covered Services received during the second and third months.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe to Molina.

<u>If You do not pay the full Premium payment by the end of the grace period, this Agreement will terminate.</u> You will still be responsible for any unpaid Premiums You owe Molina for the grace period if You receive advance payment of the premium tax credit.

Termination or nonrenewal of this Agreement for non-payment will be effective at 11:59 p.m. on:

- The last day of the grace period if You do not receive advance payment of the premium tax credit; or,
- The last day of the first month of the grace period if You receive advance payment of the premium tax credit.

Termination Notice

Upon termination of this Agreement, Molina 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.

Reinstatement after Termination

If permitted by the Marketplace, We will allow reinstatement of Your Agreement (without a break in coverage) provided the reinstatement is a correction of an erroneous termination or cancellation action.

Re-enrollment After Termination for Non-Payment

If You are terminated for non-payment of premium and wish to re-enroll with Molina (during Open Enrollment or a Special Enrollment Period) in the following plan year, We may require that You pay any past-due premium payments, plus Your first month's premium payment in full, before We will accept Your enrollment to become effective with Molina.

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Member?

The rights and responsibilities below are also posted on the Molina web site: MolinaMarketplace.com.

Your Rights

You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities
- Choose Your "main" doctor from Our list of Participating Providers (This doctor is called Your PCP)
- 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.
- 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 or Your care
    - You can call, fax, e-mail, or write to Our Customer Support Center.
- Appeal Molina's decisions
    - You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina (leave the Molina product)

- Ask for a second opinion about Your health condition
- Ask for someone outside Molina 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, Your providers, or Your health in the language You prefer
- Ask for and get materials in other formats upon request and in a timely fashion appropriate for the format being requested and in accordance with applicable state laws, such as:
    - Larger size print
    - Audio
    - Braille
- Receive instructions on how You can view online, or request a copy of, Molina's non-proprietary clinical and administrative policies and procedures
- Get a copy of Molina'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's contracted hospitals
- Not to be treated poorly by Molina or Your doctors for acting on any of these rights
- Make recommendations regarding Molina'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 Molina did not meet Your linguistic needs

*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 Your doctor, provider, or Molina information they need to care for You
- Be active in decisions about Your health care
- Follow the care plans for You that You have agreed upon 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 ID card when getting medical care
    - Do not give Your ID card to others
    - Let Molina know about any fraud or wrongdoing
- 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
- 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 Our 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 is Always Improving Services

Molina makes every effort to improve the quality of health care services provided to You. Our formal process to make this happen is the "Quality Improvement Process."

Molina 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 Us 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 is always looking for ways to take better care of Our Members. That is why Molina has a process to find 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 to add it as a new treatment for Molina Members.

For more information on new technology, please call Our Customer Support Center.

What Do I Have to Pay For?

Please refer to the "Schedule of Benefits" 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
- You ask for and get health care services from a doctor or hospital that is not a Participating Provider without getting Prior Authorization from Molina, except in the case of Emergency Services

If Molina fails to pay 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.

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 drug that was approved or does not require approval, Molina will pay You back. You must submit Your claim for reimbursement within 12 months from the date you made the payment.

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. You should also include the name of the Member for whom you are submitting the claim and Your policy number.

If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to Our 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 Your claim is denied, We will send You a letter telling You why.

If You do not agree with this, You may appeal by calling Us toll-free at 1 (888) 560-5716, Monday through Friday, 8:00 a.m. to 7:00 p.m. ET.

How Does Molina Pay for My Care?

Molina contracts with providers in many ways. Some Molina Participating Providers receive a flat amount for each month that You are under their care, whether You see the provider or not.

Some providers work on a fee-for-service basis. This means that they receive payment for each procedure they perform.

Some providers may receive incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization.

For more information about how providers are paid, please call Our 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 if You prefer to speak a language other than English. Molina can help You find a doctor that speaks Your language or have an interpreter help You.

Molina offers telephonic interpreter services to help You with:

- Making an appointment
- Talking with Your doctor or nurse
- Getting Emergency Services 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 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.

Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Our Customer Support Center at 1 (888) 560-5716.

Cultural and Linguistic Services

Molina 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 Our Customer Support Center at 1 (888) 560-5716.

COORDINATION OF BENEFITS

This Coordination of Benefits ("**COB**") provision applies when a person has health care coverage under more than one Plan. For purposes of this COB provision, "Plan" has the meaning in the definition below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is the "**Primary Plan**." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**." The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions (applicable to this COB provision)

A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured) ; medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by S. 641.31(7), F.S. and S. 627.4235(5), F.S.; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, We treat each of the parts as a separate Plan.

- "**This Plan**" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may reduce because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

- "**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance, and Copayments, is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service is an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, then any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by 2 or more Plans that provide benefits or services based on negotiated fees, then an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.

   However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

"**Closed Panel Plan**" is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that are contracted with or employed by the Plan. This type of plan excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"**Custodial Parent**" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person has coverage by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as

a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed. In which case, the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child has coverage under more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan receives notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-Custodial Parent; and then
- The Plan covering the spouse of the non-Custodial Parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same

person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan. In that case, the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect On The Benefits Of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a Member has coverage in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Molina needs certain facts about health care coverage and services to apply these COB rules and to determine benefits payable under This Plan and other Plans. Molina may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable. If You do not provide Us the information We need to apply these rules and determine the benefits payable, We will deny Your claim for benefits.

Facility of Payment

A payment made under another Plan may include an amount that Molina should have paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. Molina will treat that amount as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Molina is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaints and Appeals" section below.

If You are still not satisfied, You may call the Florida Department of Financial Services, Division of Consumer Services for instructions on filing a consumer complaint. Call 1 (877) 693-5236, or visit the Department's website at http://www.myfloridacfo.com/Division/Consumers/.

COMPLAINTS AND APPEALS

COMPLAINTS

What if I Have a Complaint?

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

- Call Us toll-free at 1 (888) 560-5716, Monday through Friday, 8:00 a.m. - 7:00 p.m. ET.
- Hearing-impaired Members may call Our toll-free TTY number at 1 (800) 955-8771, or dial 711.
- 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.
Attention: Complaints and Appeals Coordinator
PO Box 521838
Miami, Florida 33152-1838
Fax: 1 (877) 508-5748
molinahealthcare.com/marketplace

- You can also 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

GRIEVANCES

A grievance is a written complaint submitted by You or on Your behalf to Us or to a state agency regarding the:

- Availability, coverage for the delivery, or quality of health care services;
- Claims payment, handling, or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between You and Us.

We will provide You the grievance procedure upon request for the purpose of addressing complaints and grievances. You must submit a grievance within one year after the date of occurrence of the action that initiated the grievance.

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.

"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

You 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.
Attention: Complaints and Appeals Coordinator
PO Box 521838
Miami, Florida 33152-1838
1 (888) 560-5716
TTY 1 (800) 955-8771, or dial 711
Fax: 1 (877) 508-5748
MolinaMarketplace.com

You or Your Authorized Representative 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. It will include input from health care professional in the same or similar specialty as typically manages the type of medical service under review.

TIME FRAME FOR RESPONDING TO APPEAL

REQUEST TYPES	TIME FRAME 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

Your coverage will remain in effect pending the outcome of Your internal appeal.

Exhaustion of Process

The foregoing procedures and processes 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 an Adverse Benefit Determination. 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 by fax at 1 (888) 866-0205, online at externalappeal.com or by mail at:

HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534.

If You have any questions or concerns during the external appeal process, You or Your Authorized Representative can call the toll-free number 1 (888) 866-6205. You or Your Authorized 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 Authorized 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 MAXIMUS Federal Services toll free at 1 (888) 866-6205, or by faxing the request to 1 (888) 866-6190, or by mailing the request to:

HHS Federal External Review Request
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534.

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
MolinaMarketplace.com

BINDING ARBITRATION

OPTION TO RESOLVE ALL DISPUTES EXCEPT MEDICAL MALPRACTICE BY BINDING ARBITRATION

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

If You and Molina agree to arbitrate, 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, 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 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 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 American Arbitration Association (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 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.

MISCELLANEOUS PROVISIONS

Acts Beyond Molina's Control

If circumstances beyond the reasonable control of Molina, 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 and the Participating Provider shall provide or attempt to provide Covered Services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers.

Neither Molina nor any Participating Provider shall have any liability or obligation for delay or failure to provide Covered Services if such delay or failure is the result of any of the circumstances described above.

Waiver

Molina’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’s right to require Your performance of any provision of this Agreement.

Non-Discrimination

Molina does not discriminate in hiring staff or providing medical care based on pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity.

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 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 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 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.

Wellness Program
Your Agreement includes access to a health activity program. The goal of the program is to encourage You to complete a health activity that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activity we encourage You to complete is described below. For more information, please contact the Customer Support phone number on your ID Card.

Annual Health Activity
We encourage You to complete the annual health activity below during the calendar year. Upon completion, Molina may work with You to support Your overall wellness.

Annual Wellness Exam

- Provides You with the opportunity to obtain either an annual comprehensive physical exam through Your PCP, or an in-home health assessment exam facilitated through Molina

Program Benefit
For participating and completing the annual health activity, you will receive a program benefit gift card. Maximum program benefit is one gift card per calendar year. You will receive the program benefit gift card by mail at the mailing address that is on file with Molina:

Annual Health Activity	Annual Program Benefit
Complete an Annual Wellness Exam	Receive a $50 Gift Card

HEALTH MANAGEMENT PROGRAMS

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.

Health Management

Molina offers programs to help You and Your family manage a diagnosed health condition. Our programs include:

- Asthma management
- Diabetes management
- Depression management
- High blood pressure management
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management

You can also enroll in any of the programs above by calling the Our Health Management Department at 1 (866) 891-2320 between 7:00 a.m. and 11:00 p.m. ET, Monday through Friday. You may also call to ask for a booklet to help you manage your diagnosed health condition.

Health Education (Smoking Cessation and Weight Control)
Molina'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. Call toll-free 1 (866) 472-9483 between 9:00 a.m. and 9:00 p.m., Monday through Friday. Ask about other services We provide, or request information to be mailed to You.

The following are the health education programs Molina has to offer You.

Smoking Cessation Program

This program offers smoking cessation services to all smokers interested in quitting the habit. 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.

Your Health Care Quick Reference Guide

Department/ Program	Type of Help Needed	Number to Call/ Contact Information
Molina Customer Support Center Department	If You have a problem with any of Our services, We want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint When in doubt, call Us first.	**Customer Support Center** **Toll Free**: 1 (888) 560-5716 8:00 a.m. to 7:00 p.m. ET Monday through Friday. **TTY:** 1 (800) 955-8771 or 711
Mental/Behavioral Health or Substance Abuse	To locate a Participating Provider for mental/behavioral health or substance abuse evaluation or therapy.	Beacon Health 1 (800) 221-5487 8:00 a.m. to 8:00 p.m. ET Monday through Friday. Fax: 1 (617) 747-1230
Health Management	To request information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	1 (866) 891-2320 7:00 a.m. to 11:00 p.m. ET Monday through Friday
Health Education	To request any information on smoking cessation and weight management	1 (866)-472-9483 9:00 a.m. to 9:00 p.m. ET Monday through Friday
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 Spanish: 1 (866) 648-3537
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 TTY: (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 1 (800) 633-4227 TTY: 1 (877) 486-2048 Medicare.gov
Department of Financial Services	The Florida Department of Financial Services is responsible for regulating health maintenance organizations. If You have a grievance against Molina, You should first call Us toll-free at 1 (888) 560-5716, and use Molina's grievance process before contacting this department.	myfloridacfo.com 1 (877)-693-5236 or TDD: 1 (800) 640-0886