2019

Molina Healthcare of Michigan, Inc. Agreement and Individual Certificate of Coverage

# Molina Marketplace
# Michigan Silver 250

880 West Long Lake Road,
Troy, MI 48098

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.

MOLINA® HEALTHCARE

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# MOLINA HEALTHCARE OF MICHIGAN, INC.
# SCHEDULE OF BENEFITS
# Silver 250

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

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

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

| **Deductible Type** | **At Participating Providers, You Pay** |
|---|---|
| **Medical Deductible**<br>(Applies only to outpatient hospital/facility services and inpatient hospital/facility services) | |
| Individual | $5,350 |
| Entire Family of 2 or more Members | $10,700 |
| **Other Deductibles** | |
| **Prescription Drug Deductible**<br>(Applies to Tier-3 and Tier-4) | |
| Individual | $400 |
| Entire Family of 2 or more Members | $800 |
| **Annual Out-of-Pocket Maximum*** | **At Participating Providers, You Pay** |
| **Individual** | $7,900 |
| **Entire Family of 2 or more Members** | $15,800 |

* 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 | You Pay | |
|---|---|---|
| **Emergency Services – Applies to Facility Charges Only (**Cost Sharing waived if admitted directly to the hospital for inpatient services. Inpatient Cost Sharing applies if admitted. Refer to "Inpatient Hospital Services" below for applicable Cost Sharing information.**)** | 30% | Coinsurance per visit deductible applies |
| **Urgent Care Services** | $50 | Copayment per visit |

Please note: You may be responsible for provider charges that exceed the allowed amount covered under this benefit for emergency/urgent care services rendered by a Non-Participating Provider. Please refer to the section of the Agreement titled "Emergency Services and Urgent Care Services" for more information.

| Outpatient Professional Services | At Participating Providers, You Pay | |
|---|---|---|
| **Office Visits** | | |
| Preventive Care and Services (Includes prenatal and first postpartum exam) | No Charge | |
| Primary Care (PCP) and Other Practitioner Care | $30 | Copayment per visit |
| Specialty Care | $75 | Coinsurance per visit |
| **Habilitative Services** | | |
| Physical and Occupational Therapy (Includes osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year) | $75 | Copayment |
| Speech Therapy (Limit of 30 visits per calendar year) | $75 | Copayment |
| **Rehabilitative Services** | | |
| Physical and Occupational Therapy (Includes osteopathic and chiropractic manipulation) (Combined benefit limit to 30 visits per calendar year) | $75 | Copayment |
| Speech Therapy (Limit of 30 visits per calendar year) | $75 | Copayment |
| Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined benefit limit of 30 visits per calendar year) | $75 | Copayment |
| Breast Cancer Rehabilitation | $75 | Copayment |
| **Mental/Behavioral Health Services** | $30 | Copayment per visit |
| **Substance Abuse Services** | $30 | Copayment per visit |
| **Autism Spectrum Disorder Services** | $30 | Copayment per visit |

| Outpatient Professional Services | At Participating Providers, You Pay | |
|---|---|---|
| **Pediatric Vision Services (for Members under age 19 only)** | | |
| **Vision Exam**<br>**S**creening and exam, limited to 1 each calendar year | No Charge | |
| **Prescription Glasses**<br>**Frames**<br>• Limited to one pair of frames every 12 months<br>• Limited to a selection of covered frames | No Charge | |
| **Lenses**<br>• Limited to one pair every 12 months<br>• Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses<br>• All lenses include scratch resistant coating, UV protection | No Charge | |
| **Prescription Contact Lenses**<br>(In lieu of prescription glasses, limited to one pair of standard contact lenses every calendar. Medically Necessary contact lenses for specified medical conditions require Prior Authorization.) | No Charge | |
| **Low Vision Optical Devices and Services**<br>(Subject to limitations. Prior Authorization applies.) | No Charge | |
| **Family Planning** | | |
| Family Planning | No Charge | |
| Treatment of Underlying Cause of Infertility | $75 | Coinsurance after deductible |

| Outpatient Hospital/Facility Services | At Participating Providers, You Pay | |
|---|---|---|
| **Outpatient Surgery and Outpatient Procedures Other than Surgery** | | |
| Professional | 30% | Coinsurance after deductible |
| Health Care Facility | 30% | Coinsurance after deductible |
| **Specialized Scanning Services** (CT Scan, PET Scan, MRI) | 30% | Coinsurance after deductible |
| **Radiology Services (e.g., X-Rays)** | $75 | Copayment |
| **Laboratory Services** | $40 | [<br>Copayment |
| **Mental Health** | | |
| Outpatient Intensive Psychiatric Treatment Programs | 30% | Coinsurance after deductible |

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

| Inpatient Hospital Services | At Participating Providers, You Pay | |
|---|---|---|
| **Medical / Surgical** | | |
| Professional | 30% | Coinsurance after deductible |
| Hospital/Facility | 30% | Coinsurance after deductible |
| **Maternity Care** (Professional and Facility services) | 30% | Coinsurance after deductible |
| **Mental Health** (Inpatient Psychiatric Hospitalization) | 30% | Coinsurance after deductible |
| **Substance Abuse** Inpatient Detoxification | 30% | Coinsurance after deductible |
| Transitional Residential Recovery Services | 30% | Coinsurance after deductible |
| **Skilled Nursing Facility** (Limited to 45 days per calendar year; Services must be billed by a Skilled Nursing Facility Participating Provider ) | 30% | Coinsurance after deductible |
| **Hospice Care** (Limited to 45 days per calendar year) | No Charge | |
| **Prescription Drug Coverage*** | **At Participating Providers, You Pay** | |
| **Tier-1** | $20 | Copayment |
| **Tier-2** | $60 | Copayment |
| **Tier-3** | 40% | Coinsurance after deductible |
| **Tier 4** | 40% | Coinsurance after deductible |
| **Tier-5** | No Charge | |
| **Mail-Order Prescription Drugs** | A 90-day supply is offered at two times the 1-month prescription cost share. | |

*For details, please refer to the section of the Certificate titled "Prescription Drug Coverage."

| Ancillary Services | At Participating Providers, You Pay | |
|---|---|---|
| **Durable Medical Equipment** | 30% | Coinsurance |
| **Home Healthcare** (Services must be billed by a Home Healthcare Participating Provider agency) Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.). | No Charge | |

| Ancillary Services | 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% plus amounts that exceed the Allowed Amount | Coinsurance per trip |
| **Other Services** | **At Participating Providers, You Pay** | |
| **Dialysis Services** (applies to facility charges only) (This is outpatient cost sharing. For inpatient dialysis, IP hospital cost sharing applies.) | $75 | Copayment |
| **Diabetes Education** | No Charge | |
| **Weight Loss Services** | No Charge | |
| **Dietitian Services** (Limited to 6 visits per calendar year) | No Charge | |
| **Eye Care Treatment** (Limited to medical treatment for medical conditions and diseases of the eye) | $75 | Copayment |

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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.

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)

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.

This Molina Healthcare of Michigan, Inc. Agreement and Individual Certificate of Coverage (also called the "**Certificate**" or "**Agreement**") is a policy issued by Molina Healthcare of Michigan, 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 Healthcare agrees to provide the Benefits and Coverage as described in this Agreement.

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

# WELCOME

Welcome to Molina Healthcare!

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

If You are a Molina Healthcare Member, this Certificate tells You what services You can get. Molina Healthcare is a Michigan licensed Health Maintenance Organization.

If You have any questions about anything in this Certificate, call Us. You can call if You want to know more about Molina Healthcare. You can get this information in another language, large print, Braille, or audio. You may call or write to Us at:

Molina Healthcare of Michigan, Inc.
Customer Support Center
880 West Long Lake Road
Troy, MI 48098
1 (888) 560-4087
MolinaMarketplace.com

If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line, toll-free, at 1 (888) 665-4629. You can also dial 711 for the Telecommunications Relay Service.

**Cancellation**

Cancellation during first 10 days: During a period of 10 days after the date the Subscriber receives the Certificate, the Subscriber may cancel the Certificate and receive from Molina Health Care a prompt refund of any Premium paid for the Certificate by surrendering the Certificate to Molina Healthcare together with a written request for cancellation. If a Subscriber pursuant to such notice returns the Certificate to Molina Healthcare at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no Certificate had been issued.

Cancellation after 10 days: A Subscriber may cancel the Certificate after the first 10 days following receipt of the policy by giving written notice to Molina Healthcare effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, Molina Healthcare shall promptly refund to the Subscriber the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

# INTRODUCTION

**Thank You for choosing Molina Healthcare as Your health plan.**

This document is Your "Molina Healthcare of Michigan, Inc. Agreement and Individual Certificate of Coverage" (Your "Agreement" or "Certificate"). The Certificate tells You:

- How You can get services through Molina Healthcare
- The terms and conditions of coverage under this Agreement,
- Your rights and responsibilities as a Molina Healthcare Member
- How to contact Molina Healthcare

Please read this Certificate completely and carefully and keep it in a safe place where You can get to it quickly. If You have special health care needs, carefully read the sections that apply to You.

**Molina Healthcare is here to serve You.**

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

- 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 Healthcare product.

Call Us toll-free at 1 (888) 560-4087 between 8:00 a.m. to 5:00 p.m. ET Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line toll-free at 1 (888) 665-4629 or by dialing 711 for the Michigan Relay Service.

Call Us if You move from the address You had when You enrolled with Molina Healthcare 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 uses 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 uses many ways to protect PHI across Our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

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

**The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice of Privacy Practices is in the next section of this Certificate. It is on Our web site at MolinaMarketplace.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center. The number is 1 (888) 560-4087.**

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

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

**Why does Molina Healthcare use or share Your PHI?**

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

**For Treatment**

Molina Healthcare may use or share Your PHI to give You, or arrange for, Your medical care. This treatment also includes referrals between Your doctors or other health care providers. For example, We may share information about Your health condition with a Specialist 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.

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at Molina Healthcare of Michigan, Inc., P.O. Box 22668, Long Beach, CA 90801 or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

**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 use or share Your PHI without getting written authorization (approval) from You?**

The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes including the following:

**Required by Law**

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

**Public Health**

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

**Health Care Oversight**

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

**Research**

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

**Law Enforcement**

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

**Health and Safety**

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

**Government Functions**

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

**Victims of Abuse, Neglect or Domestic Violence**

Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

**Workers' Compensation**

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

**Other Disclosures**

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

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

Molina Healthcare needs Your written approval to use or share Your PHI for any reason not listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- 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 You about Your own PHI
- Sharing done with Your authorization
- Incident to a use or disclosure otherwise permitted or required under applicable law
- 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) 560-4087.

**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:

Customer Support Center
880 West Long Lake Road
Troy, MI 48098
1 (888) 560-4087

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
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
1 (800) 369-1019; 1 (800) 537-7697 (TDD)
1 (312) 886-1807 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
880 West Long Lake Road
Troy, MI 48098

Phone: 1 (888) 560-4087

## HELP FOR NON-ENGLISH SPEAKING MOLINA HEALTHCARE MEMBERS

**Interpreter Services**

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

You do not need to have a minor, friend, or family member act as Your interpreter. You may wish to say things that You do not wish to share with a minor, friend or family member. Using an interpreter may be better for You. Please call the Customer Support Center toll-free at 1 (888) 560-4087.

**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) 560-4087 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) 560-4087.

If You are deaf or hard of hearing You may contact Us through Our dedicated TTY line, toll-free, at 1 (800) 665-4629 or by dialing 711 for the Telecommunications Relay Service.

If You need help understanding the enclosed information in Your language, please call Molina Healthcare Customer Support at 1 (888) 560-4087.

## DEFINITIONS

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

"**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:

- the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
- 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 Certificate that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

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

"**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 Certificate.

"**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 Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Certificate.

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 Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. 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. However, 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 Certificate.

"**Drug Formulary**" is Molina Healthcare'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, sleep apnea monitors, nebulizer machines, insulin pumps, wheelchairs, and crutches.

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could

reasonably expect that the absence of immediate medical attention could result in: 1) placing the health of the Member in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

**"Emergency Services"** mean health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

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

- Ambulatory patient care
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for a Member until 11:59 p.m. on the last day of the month that the Member turns age 19

*Pediatric dental services are not covered under this Certificate. 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 Healthcare.

"**FDA**" means the United States Food and Drug Administration.

"**Health Care Facility**" means an institution providing health care services. This can include a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a home health agency; a diagnostic, laboratory, or imaging center; and a rehabilitation or other therapeutic health setting.

"**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 Michigan buy qualified health plan coverage from companies or health plans such as Molina Healthcare. The Marketplace may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of Michigan, 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, amount, frequency, level, 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**" (also "You" or "Your") means an individual who is eligible and enrolled under the Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 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.

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

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

"**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.

"**Participating Provider**" refers to those providers (including hospitals and physicians) 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 s or for 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)
- Individual practice association (IPA) or group of licensed doctors that provides primary care services.

You may choose any available PCP listed in the Molina Provider Directory.

"**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
- and other applicable standards during the claim review.

"**Service Area**" means the geographic area in Michigan where Molina Healthcare has been authorized by the Michigan Department of Insurance and Financial Services to market individual products sold both on and off of the Marketplace, enroll Members obtaining coverage both on and off the Marketplace and provide Covered Services through approved individual health plans sold both on and off 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.

"**Subscriber**" means either:

- An individual who is a resident of Michigan, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare in accordance with the terms of this Agreement ; or
- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 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 Member under this Agreement.

Throughout this Agreement, "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 Healthcare Membership Begin?**

Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements. It is the date 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 applied:

- If You applied 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 and/or Molina and your reason for eligibility must be verified with documentation that is acceptable to the Marketplace and/or Molina. In such case, the Effective Date of coverage will be determined by the Marketplace. 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 Healthcare requires You to live in Molina Healthcare's Service Area to be eligible under this product. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. Molina requires Members to live in Molina's Service Area for this Certificate. If You have lost Your eligibility, as described in the section titled "When Will My Molina Healthcare Membership End? (Termination of Benefits and Coverage)," You may not be permitted to re-enroll.

**Dependents**

Subscribers who enroll in this product during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Except for Dependent children, Molina requires Dependents to live in Molina's Service Area in order to be eligible under this product. The following types of family members are Dependents:

- 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). For a Dependent Child Reaching the Limiting Age of 26, Coverage under this Certificate, 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 is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children).

  Dependent children living outside of Molina's Service Area are subject to the terms and conditions of this Agreement. For example, for a Dependent child's health care to be covered under this product, the health care services must be received from Molina Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of Emergency Services.
- For Child-Only Coverage, the Member's natural born or adopted children may be enrolled in this product as Dependents by the Subscriber until the Member who is the parent is no longer eligible under this Agreement

Subscriber's grandchildren do not qualify as Dependents of the Subscriber.

**Domestic Partners**

A domestic partner of the Subscriber may be allowed to enroll in this product during an open enrollment period. If enrollment of domestic partners is available, the domestic partner of the Subscriber must satisfy all of the following:

- Share a permanent residence with the Subscriber
- Have resided with the Subscriber for not less than one year (365 days)
- Be at least 18 years of age
- Be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two of the following arrangements:
- Common ownership of real property or a common leasehold interest in such property
  - Common ownership of a motor vehicle
  - A joint bank account or a joint credit account
  - Designation as a beneficiary for life or retirement benefits or under the Subscriber's last will and testament
  - Assignments of a durable power of attorney or health care power of attorney
  - Such other proof as is considered by Molina Healthcare to be sufficient to establish financial interdependency under the circumstances of a particular case
  - Not be a blood relative any closer than would prohibit legal marriage
  - Have signed jointly with the Subscriber a notarized affidavit in form and content as may be requested by Molina Healthcare
  - Have registered with the Subscriber as domestic partners if You reside in a state that provides for such registration

**PLEASE NOTE**:

A person is not eligible to enroll as a domestic partner Dependent if any of the following conditions apply:

- either such person or the Subscriber has signed a domestic partner affidavit or declaration with any other person within 12 months prior to designating each other as domestic partners under this product;
- either such person or the Subscriber is currently legally married to another person; or
- either such person or the Subscriber has any other domestic partner, spouse, or spouse equivalent of the same or opposite sex.

An eligible domestic partner's natural or adopted children who meet the Dependent eligibility requirements for enrollment in this product are also eligible to enroll as Dependent children.

**Age Limit for Children (Disabled Children)**

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

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

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

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

You must submit requests to enroll a new Dependent to the Marketplace and/or Molina Healthcare within 60 days from the date the Dependent became eligible to enroll with Molina Healthcare.

- **Spouse**

You can add a Spouse as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

  - The Spouse or domestic partner loses "minimum essential coverage" through government-sponsored programs, employer-sponsored plans, individual market plans, or any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act.
  - The date of Your marriage or domestic partnership arrangement.
  - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.
  - The Spouse permanently moves into the service area.

- **Children Under 26 Years of Age**

You can add a Dependent under the age of 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event

listed below:

- The child loses "minimum essential coverage" through government-sponsored programs, employer-sponsored plans, individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act.
- The child becomes a Dependent through marriage, birth, adoption, placement in foster care, or child support or other court order.
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **Newborn Child**

Coverage for a newborn child is from the moment of birth. If You do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date 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 to Provide Child Coverage**

When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage under this Certificate, Molina shall:

- Permit the eligible parent to enroll, in the family coverage under this Certificate, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
- If the eligible parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program.
- And, not disenroll or eliminate coverage of the child unless Molina obtains satisfactory written evidence of the following:
  - the court or administrative order is no longer in effect; or
  - the child enrolls in comparable health coverage through another health insurer or health care program that will take effect no later than the effective date of disenrollment.

However, in no event may Molina Healthcare disenroll or eliminate coverage of the child if such action is not permitted by applicable law.

- **Foster Child**

Coverage for a child placed with You or Your Spouse for foster care is the date of placement for foster care or when You or Your Spouse gain the legal right to control the child's health care, whichever is earlier.

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

shows You or Your Spouse have the legal right to control the child's health care.

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

**Discontinuation of Dependent Benefits and Coverage**

Benefits and Coverage for Your Dependent will be discontinued on:

- The end of the calendar year that the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section above titled "Age Limit for Children (Disabled Children)" for more information.
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage.
- The date the Dependent domestic partner enters a termination of the domestic partnership from the Subscriber.
- For Child-Only Coverage, the date You are no longer eligible.

**Continued Eligibility**

If You are no longer eligible for coverage under this product, We will send You a letter letting You know at least 30 days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

## MEMBER IDENTIFICATION (ID) CARD

**How Do I Know if I am a Molina Healthcare Member?**

You get a Member identification card (ID card) from Molina Healthcare. 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.

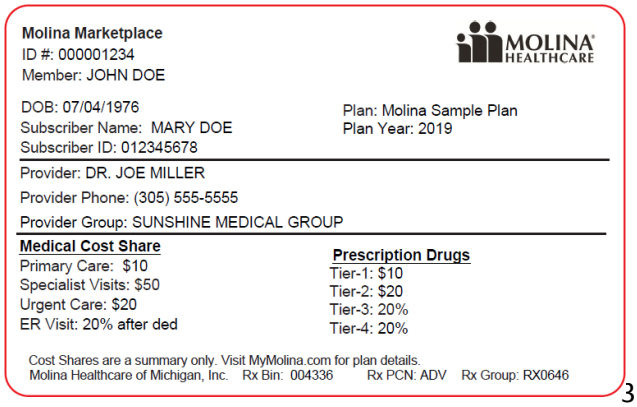
Carry Your ID card with You at all times. You must show Your ID card every time You get health care.

If You lose Your ID card or Your ID card is stolen, call Molina Healthcare toll-free at 1 (888) 560-4087. We will be happy to send You a new card.

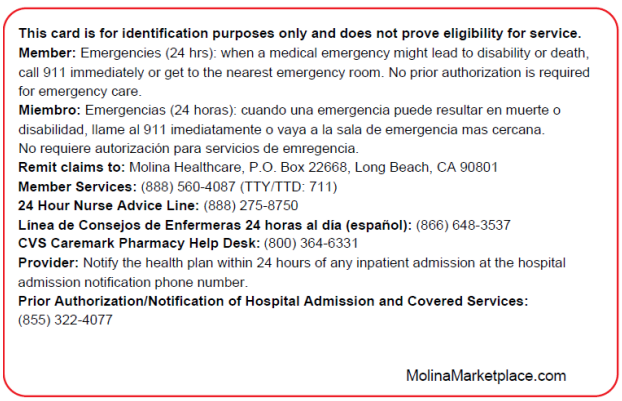
If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-4087.

**Sample ID Card**

Front:




Back:



**What Do I Do First?**

Look at Your Molina Healthcare 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 Healthcare's 24 hours Nurse Advice Line
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription questions
- The identifier for Molina Healthcare's prescription drug benefit
- Toll-free number to notify Molina that You have been admitted to the hospital
- Toll-free number to notify Molina that You have gone to the emergency room.

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 Healthcare. 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 Healthcare?**
(Choice of Doctors and Providers; Facilities)

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 Healthcare. You may visit Molina Healthcare's 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.

The first person You should call for any healthcare is Your PCP.

If You need hospital or similar services, You must go to a facility that is a Participating Provider. For more information about which facilities are with Molina Healthcare, or where they are located, call Molina Healthcare toll-free at 1 (888) 560-4087.

You may get Emergency Services in any emergency room or urgent care center, wherever located.
Except for Emergency Services, You must receive Covered 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 the Annual Out-of-Pocket Maximum.

**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 that 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. Please refer to the "Definition" section for explanation.

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. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE. | |
|---|---|
| **TYPE OF HELP YOU NEED:** | **WHERE TO GO. WHOM TO CALL.** |
| **Emergency Services** | Call 911 or go to the nearest emergency room.<br><br>Even when outside Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency Services. |
| **Urgent Care Services** | Call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish, 1 (866) 648-3537.<br><br>For out-of-area Urgent Care Services 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:<br>• Pregnancy tests<br>• Birth control<br>• 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 Molina Healthcare's Customer Support Center if You do not know an OB/GYN. |

| ALWAYS CONSULT YOUR PCP FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE. | |
|---|---|
| **To see a Specialist Physician** (for example, cancer or heart doctor) | Go to a Specialist Physician who is a Participating Provider. A referral from Your PCP is not required. If You need Emergency Services, get help as directed under "Emergency Services" or "Urgent Care Services" above. |
| **For mental/behavioral health or substance abuse evaluation** | Go to a qualified mental/behavioral health or substance abuse Participating Provider. You do not need a referral or Prior Authorization to get a mental/behavioral health or substance abuse evaluation. |
| **For mental/behavioral health or substance abuse therapy** | Go to a qualified mental/behavioral health or substance abuse Participating Provider. You do not need a referral. You do not need a Prior Authorization for outpatient office visits. |
| **To have surgery** | Go to Your PCP first. If You need Emergency Services, get help as directed under "Emergency Services" above. |
| **To get a second opinion** | Consult Molina's Provider Directory on Our website at MolinaMarketplace.com.<br><br>You can find a Participating Provider for a second opinion. |
| **To go to the hospital** | If You need Emergency Services, get help as directed under "Emergency Services" above. For non-emergency, go to Your PCP first, or go to any hospital facility that is a Participating Provider. |
| **After-hours care** | You can call Molina Healthcare's 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 Medical 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.

You may choose any available PCP listed in the Molina Provider Directory.

If You want to know more about Your PCP or other Molina Healthcare doctors, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-4087.

**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 Healthcare Participating Providers. This includes doctors, hospitals, Specialist Physicians, Urgent Care clinics or medical clinics. The exception is Emergency Services or services to an out-of-network Provider previously authorized by Molina Healthcare . For more information please refer to the section of the Agreement titled Emergency Services and Urgent Care Services. If Medically Necessary Covered Services are not available through a Participating Provider, upon prior authorization Molina Healthcare will allow a Referral to a non-Participating Provider, upon the request of Your Participating Provider and within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no event to exceed five business days after receipt of reasonably requested documentation. Molina will fully reimburse the non-Participating Provider lesser of Molina's allowed amount or the agreed upon rate. Any such request will be reviewed by a Specialist Physician of the same specialty as the provider to whom a Referral is requested.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina Healthcare's health plan. You will also learn some helpful tips on how to use Molina Healthcare's services and benefits. Visit Molina Healthcare's website at www.MolinaMarketplace.com to view Our online list of providers, or call Molina Healthcare toll-free at 1 (888) 560-4087 to receive a printed copy. A map showing the Molina Healthcare service area is also available at the back of this EOC and on Our website.

You can find the following in Molina's online Provider Directory:

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

You can also find out whether a Participating Provider is accepting new patients.

**Note: Some hospitals and providers may not provide some of the services that may be covered under this Certificate that You or Your family member might need:**

- **Family planning**
- **Birth control, including Emergency contraception**
- **Sterilization (including tubal ligation at the time of labor and delivery)**
- **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) 560-4087 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. Or You may want to choose one doctor for Yourself and another one for Your family members.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You 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 Molina Healthcare toll-free at 1 (888) 560-4087.

Molina Healthcare can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina Healthcare doctor.

**What if I Do Not Choose a PCP?**

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

## Changing Your Doctor

**What if I Want to Change my PCP?**

You can change Your PCP at any time.

- All changes made by the 25th of the month will be in effect on the first day of the following calendar month.
- Any 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 Healthcare 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-adherent behavior)
- You are being abusive, threatening, or have violent behavior
- Your relationship with Your Doctor breaks down

**How Do I Change My PCP?**

Call Molina Healthcare toll-free at 1 (888) 560-4087, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET. You may also visit Molina Healthcare's 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 Healthcare.
- The PCP already has all the patients he or she can take care of right now.

**What If My Doctor or Hospital Is No Longer with Molina Healthcare?**

If Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina Healthcare, We will send You a letter to let You know. The letter will tell You how the change affects You.

If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. Our Molina Healthcare Customer Support Center staff can help You make a choice.

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

**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.

**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 90 days, whichever is shorter, at in-network Cost Sharing.

An "Active Course of Treatment" is:

- an ongoing course of treatment for a Life-Threatening Condition;
- an ongoing course of treatment for a Serious Acute Condition;
- the second or third trimester of pregnancy through the postpartum period; or

- 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 ongoing 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 the 90th day of continuity of care
- upon completion of the 90th day 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 an agreed upon rate for such services. If Molina and the provider are unable to settle on an agreed upon rate, You may be responsible to the provider for any billed amounts that exceed Molina's Allowed Amount. That would be in addition to any in-network Cost-Sharing amounts that You owe under this EOC. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Your Deductible or Your Annual Out-of-Pocket maximum.

**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.

4. For Inpatient Services: With Your assistance, Molina may reach out to any prior Insurer (if applicable) to determine Your prior Insurer's liability 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.

**What If There Is No Participating Provider to Provide a Covered Service?**
In the event Medically Necessary Covered Services are not reasonably available through Participating Providers, You may request Prior Authorization review to determine whether obtaining Covered Services from a Non-Participating Provider would be warranted by Medical Necessity review for the specifically requested medical condition.

If Covered Services are not reasonably available by Participating Providers, Molina will evaluate the Medical Necessity of such services requested by Your PCP, Specialist or Other Practitioner, and if warranted provide access to Non-Participating Providers as Covered Services for the specifically requested medical condition . Molina will pay the Non-Participating Provider at the lesser of Molina's Allowed Amount or an agreed upon rate. You will only be responsible for the Copayment amount shown in the Schedule of Benefits.

In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances. Please refer to the Continuity of Care section of this document for full details.

**If You receive a bill, other than for your Cost Sharing as shown in the Schedule of Benefits, from your provider (balance bill), You should contact Molina's Member Services department at the phone number on Your ID card24-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 at 1 (888) 275-8750. For Spanish, call 1 (866) 648-3537.

If You are deaf or hard of hearing access Nurse Advice with the Telecommunications Relay Service by dialing 711.

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

**Getting an Appointment with a Participating Provider**

Your doctor's office should give You an appointment within the periods listed below.

| Appointment Type For PCPs | When You should get the appointment |
|---|---|
| Urgent care appointments for Covered Services | Within 48 hours of the appointment request |
| Routine or non-urgent care appointments | Within 10 working days of the appointment request |
| Non-urgent care appointments with a non-physician behavioral health care provider | Within 10 working days of the appointment request |
| **Appointment Type For Specialist Physicians** | **When You should get the appointment** |
| Urgent care appointments for Covered Services | Within 48 hours of the appointment request |
| Routine or non-urgent care appointments | Within 15 working days of the appointment request |

**What is a Prior Authorization?**

A Prior Authorization is a 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:**

- Emergency Services
- Family planning services
- Habilitative services
- Hospice inpatient care (notification only, Prior Authorization is not required)
- Human Immunodeficiency Virus (HIV) testing and counseling
- Manipulative treatment services, including chiropractic services
- The following outpatient 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)
- Office-based procedures
- The following outpatient substance abuse services:
    - Individual and group substance abuse counseling
    - Outpatient 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)
- The following rehabilitative services
    - Cardiac therapy
    - Pulmonary therapy
- Services for sexually transmitted diseases
- Urgent Care services from a Participating Provider

**You must get Prior Authorization for the following services, except Emergency Services or in-network Urgent Care Services:**

- All inpatient admissions (except hospice)
- Certain Ambulatory Surgery Center service (ASC)*
- Certain drugs as indicated on the published Drug Formulary*
- Certain Durable Medical Equipment*
- 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
- Certain outpatient hospital service*
- Colonoscopy for Members under age 50
- 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
- Formulary Specialty (Oral and Injectable) drugs
- Home healthcare and home infusion therapy (after 7 visits for home settings)
    - Hyperbaric therapy
- Imaging and special tests. Examples are:
    - CT (Computed Tomography)
    - MRI (Magnetic Resonance Imaging)
    - MRA (Magnetic Resonance Angiogram)
    - PET (Positron Emission Tomography) scan
- Low vision follow-up care
- Medically Necessary genetic testing
- Occupational Therapy (after initial visit plus 12visits/year for outpatient and home settings)
- Pain management services and procedures
- Physical Therapy (after initial visit plus 12 visits/year for outpatient and home settings)
- Radiation therapy and radio surgery
- Speech Therapy (after 7 visits for outpatient and home settings)
- Services rendered by a Non-Participating Provider
- Sleep studies (except home sleep studies)
- Substance Abuse Services:
    - Inpatient services
    - Day Treatment
    - Detoxification Services
    - Partial hospitalization
- Transplant evaluation and related services including Solid Organ and Bone Marrow (Cornea transplant does not require Prior Authorization)
- Non-Emergency Air Ambulance
- Any other services listed as requiring Prior Authorization in this COC

*Call Molina Healthcare's Customer Support Center at 1 (888) 560-4087 if You need to determine if Your service needs Prior Authorization.

If Molina Healthcare denies a request for a Prior Authorization, You may appeal that decision as described below. If You or Your provider decide to proceed with the services that have been denied 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 Molina Healthcare toll-free at 1 (888) 560-4087. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

We will be happy to send You a general explanation of how Prior Authorization decisions are made. We can also send You a general explanation of the overall approval process if You request it.

Routine Prior Authorization requests will be processed within 5 business days. This is 5 days from when We get the information We need and ask for from You or Your provider. We need this information to make the decision. A Prior Authorization may be denied because information We request is not provided to Us. Molina will respond to the Prior Authorization request within 14 calendar days from the receipt of the request.

We process Prior Authorizations for medical conditions that may cause a serious threat to Your health within 24 hours. This is 24 hours from when we get the information we need and ask for. We need this information to make the decision. 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 right away. This is done by phone.

If a service is not Medically Necessary or is not a Covered Service, request for the service may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision.

The denial letter will tell You how to appeal. These instructions are also noted in the section of this Certificate titled "Grievances (Internal Appeals) and External Appeals."

**Standing Approvals**

If You have 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 to receive 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 Healthcare's physicians and Specialist Physicians. They will ensure You receive a treatment plan based on Your medical needs.

If You have any difficulty getting a standing approval, call Molina Healthcare toll-free at 1 (888) 560-4087. You may also call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

If You feel Your needs have not been met, please refer to Molina Healthcare's grievance and appeal process, which is described in the section of this Certificate titled "Complaints."

**Utilization Review**

The Healthcare Services Department conducts concurrent review on inpatient cases and processes Prior Authorization requests.

Prior authorization timeframes can be found under the section titled "Prior Authorization".

Customer Service and Health Care Service Department are available 8:00AM to 5:00PM plus after hour voicemail. Molina Healthcare toll-free at 1 (888) 560-4087. You may also call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service. HCS retrieves and triages or responds to all messages no later then the next business day. Urgent requestes should receive return call the same day.

Inbound and Outbound communications may be in the form of fax, electronic or telephone communications.

Inpatient review timeframes are as follows:

| | |
|---|---|
| **For non-emergency admissions:** | You or a member of Your family, Your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted. |
| **For an emergency admission:** | You or a member of Your family, Your physician or the facility should call within 24 hours or as soon as reasonably possible after you have been admitted. |
| **For outpatient and inpatient non-emergency medical services requiring prior authroization:** | You or a member of Your family, Your physician or the facility must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled. |
| **For inpatient acute care** | Utilization Review will coordinate services within 48 hours and will continue to follow up every 48 hours. |

Upon request in writing or via telephone, practitioners and members requesting authorization for procedures, equipment, or pharmaceuticals for medical, surgical, or behavioral health services will be provided the criteria used for making final coverage determinations. Criteria specific to the request can be mailed, faxed, or provided verbally to the practitioner or member by the Medical Director or their designee(s).

Healthcare Services staff provides assitance and alternatives for care when a member is not authroized for a requested service.

**Second Opinions**

You or Your PCP may want another doctor (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. Please consult Molina's Provider Directory on Our website at MolinaMarketplace.com to find a Participating Provider for a second opinion. We only cover second opinions when furnished by a Participating Provider.

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

- Your symptoms are complex or confusing.
- Your doctor is not sure the diagnosis is correct.

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

## EMERGENCY SERVICES AND URGENT CARE SERVICES

### What is an Emergency?

"Emergency Services" mean health care services needed to evaluate, stabilize or treat an Emergency Medical Condition**.** Emergency Services are covered up to the point of stabilization of the Emergency Medical Condition.

An "Emergency Medical Condition" includes a medical, psychiatric or substance abuse condition having acute and severe symptoms (including severe pain) or involving active labor. If immediate medical attention is not received, an Emergency could result in any of the following:

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

Emergency Services also includes Emergency contraceptive drug therapy. Services provided within an emergency room that are not Emergency Services or do not meet the definition of an Emergency Medical Condition are considered non-emergency and will not be covered.

### How do I get Emergency Services?

Emergency Services are available 24 hours a day, 7 days a week for Molina Healthcare Members. If You think You have an Emergency, wherever You are:

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

You **never** need a referral or Prior Authorization for Emergency Services.

When You go for Emergency Services, bring Your Molina Healthcare Member ID card with You.

If You are not sure if You need Emergency Services but You need medical help, 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.

The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing, please use the Telecommunications Relay Service by dialing 711.

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 Healthcare's Service Area and I need Emergency Services?

Go to the nearest emergency room for care.

Contact Molina Healthcare within 24 hours, or when medically reasonable, of getting Emergency Services. Call toll-free at 1 (888) 560-4087. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629.

When You are away from Molina Healthcare'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 a Participating Provider when You are within Molina Healthcare'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 Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish call 1 (866) 648-3537 for directions.

Our nurses can help You any time of the day or night. They will tell You what to do or where to go to be seen.

If You are within Molina Healthcare's Service Area and have already asked Your PCP the name of the urgent care center that You are to use, go to the urgent care center.

It is best to find out the name of the urgent care center ahead of time. Ask Your doctor for the name of the urgent care center and the name of the hospital that You are to use.

If You are outside of Molina Healthcare's Service Area, go to the nearest emergency room.

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits, You must get services from a Participating Provider. 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. You may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Urgent Care services rendered by a Non-Participating Provider.

**Emergency Services Rendered by a Non-Participating Provider**

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

**Important:** Except as otherwise required by state law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina will calculate the allowed amount as the greatest of the following:

- Molina's allowed amount for such services, or
- An agreed upon rate for such services

Because Non-Participating Providers are not in Molina's contracted provider network, they may balance-bill You for the difference between Our Allowed Amount, described above, and the rate

that they charge. You may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Urgent Care services rendered by a Non-Participating Provider.**Services of Specified Non-Participating 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, Molina shall pay as long as the care is:

- 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 determine the Allowed Amount covered for these services as the lesser of Molina's Allowed Amount or an agreed upon rate in compliance with state law. That amount is subject to 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, described above, 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.

**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 better to 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) 560-4087. You may also call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (888) 665-4629 or 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 Molina Healthcare toll-free at 1 (888) 560-4087. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m. ET. We will be happy to assist You.

Molina Healthcare offers a special program to Our pregnant Members called Motherhood Matters®. This program provides important information about diet, exercise and other topics related to Your pregnancy.

For more information, call the Motherhood Matters® pregnancy program toll-free at 1 (866) 891-2320, Monday through Friday, 7:00 a.m. to 11:00 p.m. ET.

## 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 Healthcare and its contractors to make reasonable accommodations for patients with disabilities.

### Physical Access

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

If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at 1 (888) 560-4087. You may also call Our dedicated TTY line toll-free at 1 (888) 665-4629. A Customer Support Center Representative will help You find another doctor.

### Access for the Deaf or Hard of Hearing

Call Molina Healthcare's Customer Support Center through Our TTY Number toll-free at 1 (888) 665-4629, or dial 711 for the Telecommunications Relay Service.

### Access for Persons with Low Vision or Who are Blind

This Certificate and other important information 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 Certificate is also available in an audio format.

For accessible formats, or for direct help in reading the Certificate and other materials, please call Molina Healthcare toll-free at 1 (888) 560-4087. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina Healthcare's Customer Support Center.

**Disability Access Grievances**

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

# BENEFITS AND COVERAGE

Molina Healthcare covers the services described in the section titled "What is Covered Under My Plan?" below. These are subject to the exclusions, limitations, and reductions set forth in this Certificate. 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 Certificate
- You receive the Covered Services from Participating Providers inside Our Service Area for this product offered through the Marketplace, except where specifically noted to the contrary in this Certificate – e.g., in the case of out-of-area Emergency Services.

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

## 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 Certificate.

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 Certificate. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members. This is determined by the Marketplace's rules.

For services, such as laboratory and x-ray that are provided on the same date of service as an office visit to a PCP or a specialist, you will only be responsible for the applicable cost sharing amount for the office visit.

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:

- the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
  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 Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare 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 Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Certificate.

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 Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. 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 Certificate for the Cost Sharing amount You will be required to pay for Covered Services listed.

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

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this Certificate, You pay the Cost Sharing in effect on Your admission date until You are discharged if the services are covered under Your prior health plan You must also have had no break in coverage. If the services are not covered under Your prior health plan, 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 Healthcare 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 most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the Covered Services You receive. 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 Certificate. However, You are responsible for paying charges for any health care services or treatments that are:

- not Covered Services under this Certificate, or
- 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 be described in this Certificate.

Your Essential Health Benefits coverage includes at least the 10 categories of benefits identified in the definition.

You cannot be excluded from coverage in any of the 10 EHB categories. However, You will not be eligible for pediatric Covered Services under this Agreement as of 11:59 p.m. on the last day of the month that You turn age 19. This includes pediatric dental that can be purchased separately through the Marketplace and pediatric vision.

The Affordable Care Act provides certain rules for Essential Health Benefits that tell Molina how to administer certain benefits and Cost Sharing under this Certificate. 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 Certificate.

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 Essential Health Benefits does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

**Making Your Coverage More Affordable**

For qualifying Subscribers, there may be assistance to help make the product that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Marketplace:

- To determine if You are eligible for tax credits to reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits.
- For information about any annual limits on Cost Sharing towards Your Essential Health Benefits.
- To determine if You are a qualifying American Indian or Alaska Native who has limited or no Cost Sharing responsibilities for Essential Health Benefits.

Molina Healthcare will work with the Marketplace to help You.

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

**WHAT IS COVERED UNDER MY PLAN?**

This section tells You what medical services Molina Healthcare covers, also known as 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, refer to the "Grievances (Internal Appeals) and External Appeals" section of this Certificate.

In general, Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Molina Healthcare also may cover routine medical costs for Members in Approved Clinical Trials. To learn more, refer to the section of this

Certificate titled "Approved Clinical Trials."

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, turn to the section of this Certificate titled "What Is A Prior Authorization?" Prior Authorization does not apply to Emergency Services provided in an emergency room.

# 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, current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention, as well as preventive care services and screenings specified in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Scheduled prenatal care exams and first postpartum follow-up consultation exam.

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. A list of USPSTF recommended preventive health services is available at www.uspreventiveservicestaskforce.org.

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 Michigan law. These coverage limitations also are applicable to the preventive care benefits listed below.

To help You understand and access Your benefits, preventive services for adults and children that are covered under this Certificate 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 furnished by a Participating Provider:

- Alcohol and drug use assessment: adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health education, nutrition assessment, and psychological services.
- Autism screening – children 18 and 24 months
- 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: children
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidema screening: children at higher risk of lipid disorder
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21, including those with special health care needs.
- Gonorrhea prophylactic medication: newborns
- Health education
- Hearing screening for newborns
- Hematocrit or hemoglobin screening: children of all ages
- 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 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 per 6-month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Routine preventive hearing screenings
- Sexually transmitted infection prevention counseling: adolescents at higher risk
- Screening for hepatitis B virus infection in persons at high risk for infection.
- Sickle cell trait screening, when appropriate
- Tuberculosis (TB) screening

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

**Preventive Services for Adults and Seniors**

The following outpatient preventive care services are covered and recommended for adults, including seniors. You will not pay any Cost Sharing if furnished by a Participating Provider:

- Abdominal aortic aneurysm screening: for male former smokers age 65 - 75 – limit one per year
- 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 adults who are at increased risk for sexually transmitted infections.
- BRCA screening, counseling about breast cancer preventive medication
- Breast cancer chemoprevention counseling for women at high risk
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies, and counseling
- Cancer screening including cervical cancer
- Chlamydial infection screening: women
- Cholesterol check
- Colorectal cancer screening (based on Your age or increased medical risk)
- Depression screening: adults
- Diabetes (Type 2) screening for adults with high blood pressure
- Falls prevention in older adults: exercise or physical therapy
- Family planning services
- Folic acid supplementation
- Gonorrhea screening and counseling – all women at high risk
- Health education
- Healthy diet counseling
- Hepatitis B screening: pregnant women
- Hepatitis C virus infection screening: adults
- High Blood Pressure Screening
- HIV screening: pregnant women
- Immunizations
- Mammogram for women (based on Your age)
- 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 (age 65 and over )
- Pap smear for women (based on Your age) and health status including human papilloma virus (HPV) screening test
- Prostate specific antigen testing
- Rh incompatibility screening: 24-28 weeks gestation

- Rh incompatibility screening: first pregnancy visit
- Skin cancer behavioral counseling age 10 to age 24
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam, of high-risk pregnancy
- 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 preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- STDs and HIV screening and counseling
- Syphilis screening and counseling – all adults at high risk
- Tobacco use counseling and interventions
- Tuberculosis (TB) screening
- Well-woman visits

**PHYSICIAN SERVICES**

We cover the following outpatient physician services:

- 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 and treatments when provided or referred by Your PCP
- Physician care in or out of the hospital
- Consultations and well-child care
- Routine examinations and prenatal care provided by an OB/GYN to female Members
- Evaluation and treatment of chronic and/or acute pain
- Allergy testing

**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.

Please note that the visit limits for physical therapy, occupational therapy, and speech therapy in the Schedule of Benefits do not apply when those therapies are provided under the Autism Spectrum Disorder benefit.

**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.

These services may also include cardiac and pulmonary rehabilitation, breast cancer rehabilitation, and osteopathic and chiropractic manipulation.

Please note that the visit limits for physical therapy, occupational therapy, and speech therapy in the Schedule of Benefits do not apply when those therapies are provided under the Autism Spectrum Disorder benefit.

**OUTPATIENT MENTAL 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

We cover outpatient mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.
"**Mental Disorders**" include the following conditions:

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

**OUTPATIENT SUBSTANCE ABUSE SERVICES**

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

- Day-treatment programs
- Intensive outpatient programs
- Individual and group substance abuse counseling
- Medical treatment including prescription drugs for withdrawal symptoms (e.g. detoxification)
- Individual substance abuse diagnostic evaluation, medical testing, 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 Services" section.

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

**Dental Anesthesia**

For Medically Necessary dental procedures, We cover general anesthesia and the Participating Provider facility's services associated with the anesthesia if all of the following are true:

- You are under age 7, or You are developmentally disabled, or Your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other services related to the dental procedure, such as the dentist's services.

**Dental and Orthodontic Services for Cleft Palate**

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

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

**Services to Treat Temporomandibular Joint Syndrome ("TMJ")**

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

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

**Oral Surgery**

We cover the following oral surgery services; treatment of fractures of facial bones; biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, and salivary glands and ducts; rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defects or accidental injury; medical surgical services required to correct accidental injuries; treatment for oral and/or facial cancer; treatment for conditions affecting the mouth other than the teeth. Prior Authorization is required for these services.

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.

**DIABETES SERVICES**

We cover the following diabetes-related services:

- Diabetic eye examinations (dilated retinal examinations)
- Routine foot care for Members with diabetes

**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 pediatric services for a Member until 11:59 p.m. on the last day of the month that the Member turns age 19:

- Routine vision screening and eye exam every calendar year.
- Prescription glasses (frames and lenses) - limited to one pair of prescription eye glasses once every 12 months
    - Covered frames include a 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, and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Contact Lenses: limited to 1 pair of standard contact lenses every calendar year, in lieu of prescription lenses and frames, includes evaluation, fitting, and follow-up care. 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 with follow-up care, when services are Medically Necessary and Prior Authorization is obtained. With Prior Authorization, coverage includes:

    - one comprehensive low visions evaluation every 5 years
    - high-powered spectacles and magnifiers as Medically Necessary

- follow-up care – 4 visits in any 5-year period

Laser corrective surgery is not covered.

**Autism Spectrum Disorder**

We cover diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the diagnostic and statistical manual, for Members 18 years and younger.

Treatment includes the following that are determined to be Medically Necessary by a Participating Provider who is a licensed physician, psychologist or social worker: behavioral health treatment, pharmacy care, psychiatric care, psychologist care, and therapeutic care.

We cover habilitative services, such as; speech therapy, occupational and physical therapy. We also cover applied behavioral analysis for the treatment of autism spectrum disorder.

Applied behavioral analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Coverage of diagnosis and treatment of autism spectrum disorders are subject to the following:

- review by Molina Healthcare of a treatment plan and treatment to ensure consistency with current protocols
- the receipt by Molina Healthcare of the results of the autism diagnostic observation schedule used in the diagnosis
- upon Molina Healthcare's request, the performance of the autism diagnostic observation schedule not more frequently than once every 3 years
- upon Molina Healthcare's request, that an annual development evaluation be conducted and the results of the annual development evaluation be submitted to Molina

**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 FDA.

As a Member, You pick a doctor who is located near You to receive the services You need. Our PCPs, including OB/GYN Specialist Physicians, are available for family planning services. You can make an appointment without having to get Prior Authorization from Molina Healthcare. Molina Healthcare 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 (IUDs)

- Follow-up care for any problems You may have using birth control methods issued by the family planning providers, including insertion and extraction of IUDs
- 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

Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of covered services are sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy. Services for treatment of underlying cause of infertility are subject to cost sharing. We do not cover services and supplies relating to treatment of infertility.

Family planning services do not include:

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

## PREGNANCY TERMINATIONS

Molina Healthcare may not cover elective abortions as directed by the State of Michigan and the Michigan Abortion Insurance Opt Out Act that went into effect March 13, 2014.

Elective abortions are defined by the State of Michigan as follows and may not be covered under Your policy with Molina Healthcare of Michigan, Inc. as of March 13, 2014:

- The intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman.

Per the Abortion Insurance Opt Out Act, elective abortion does not include any of the following and will, therefore, continue to be covered under Your policy with Molina Healthcare of Michigan, Inc.:

- The use or prescription of a drug or device intended as a contraceptive.
  The intentional use of an instrument, drug, or other substance or device by a physician to terminate a woman's pregnancy if the woman's physical condition, in the physician's reasonable medical judgment, necessitates the termination of the woman's pregnancy to avert her death.
- Treatment upon a pregnant woman who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.

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 an 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.**

### FOOD, SUPPLEMENTS AND FORMULAS

Molina Healthcare covers supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. We cover formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy.

Molina Healthcare also covers supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies, and equipment needed to administer this type of nutrition are covered.

## 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 Health Care Facility services.**

### 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 Health Care Facility services.**

Please note, if you are seen in a hospital based clinic, outpatient hospital benefits may apply.

Coverage includes those drugs administered in the course of the procedure, such as antineoplastic surgical drugs. Separate Cost Sharing may apply for professional services and Health Care Facility services. **Separate Cost Sharing may apply for professional services and Health Care Facility services.**

### 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 Health Care Facility services. Prior Authorization is required. 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. Separate Cost Sharing may apply for professional services and Health Care Facility 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 the Annual Out-of-Pocket Maximum.

### LABORATORY SERVICES

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 the 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
- Breast cancer diagnostic services

### MENTAL 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

### OUTPATIENT BREAST CANCER TREATMENT

We cover outpatient breast cancer treatment which means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

For Covered Services related to outpatient breast cancer treatment, You will pay the Cost Sharing You would pay if the services were not related to outpatient breast cancer treatment. For example, see "Outpatient Surgery" under "Outpatient Hospital/Facility Services" in the Schedule of Benefits for the Cost Sharing that applies for outpatient surgery care.

## INPATIENT HOSPITAL SERVICES

### INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency Services. However, 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 the Annual Out-of-Pocket Maximum.

**MEDICAL/SURGICAL SERVICES**

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

- Surgical services
- 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
- 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
- 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
- Antineoplastic surgical drugs

**MATERNITY CARE**

We cover maternity care services related to labor and delivery. Coverage after delivery provided is as follows:

- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section) from the time You deliver or from the time You are admitted if delivery occurs outside of the hospital, with no Prior Authorization required. For longer stays Prior Authorization is still not required, but You or a Participating Provider must notify Molina before extending the time in the hospital. 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 Healthcare will cover post discharge services and laboratory services. Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable. Laboratory Tests Cost Sharing will apply to laboratory services).

## MENTAL HEALTH INPATIENT PSYCHIATRIC HOSPITALIZATION

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

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

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"Mental Disorders" covered under this Certificate include Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

## SUBSTANCE ABUSE INPATIENT DETOXIFICATION

We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of withdrawal symptoms, including room and board, Participating Provider physician services, prescription drugs, dependency recovery services, education, and counseling; as well as medically monitored inpatient treatment following full or partial recovery from acute detoxification symptoms.

## SUBSTANCE ABUSE TRANSITIONAL RESIDENTIAL RECOVERY SERVICES

We cover substance abuse treatment such as counseling, detoxification services, prescription drugs, and ancillary services such as medical testing, diagnostic evaluation in a nonmedical transitional residential recovery setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment.

## SKILLED NURSING FACILITY

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

- Room and board
- Physician and nursing services
- Medications
- Injections

You must have Prior Authorization for these services before the services begin. You will continue to get care without interruption. Services must be billed by a Skilled Nursing Facility Participating Provider

The SNF benefit is limited to 45 days per calendar year.

**HOSPICE CARE**

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

- Home hospice services
- A semi-private room in a hospice facility limited to 45 days per calendar year
- Dietitian 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 is short-term inpatient care provided in order to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short-term inpatient care
- Pain control
- Symptom management
- Physical therapy, occupational therapy, and speech-language therapy, when provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for Members who are diagnosed with a terminal illness and have a life expectancy of 12 months or less. They can choose hospice care instead of the traditional services covered by the product.

Please contact Molina Healthcare for further information. You must receive Prior Authorization for all inpatient hospice care services.

**APPROVED CLINICAL TRIALS**

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

- Be enrolled for coverage under 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 Healthcare

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and

(1) the study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or

(2) the study or investigation is conducted under an investigational new drug application reviewed

by the FDA, or

(3) the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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 Healthcare or Your PCP for further information.

If You qualify, Molina Healthcare cannot deny Your participation in an approved clinical trial. Molina Healthcare 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 Certificate 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.

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

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

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

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

**BARIATRIC SURGERY**

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Participating Provider physician services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the medical group-approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long-term bariatric surgery success
- A Participating Provider physician who is a Specialist Physician in bariatric care determines that the surgery is Medically Necessary

For Covered Services related to bariatric surgical procedures, You will pay the Cost Sharing You

would pay if the Covered Services were not related to a bariatric surgical procedure. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

Surgical treatment of obesity is limited to once per lifetime unless Medically Necessary, a second obesity surgery is not Covered, even if the initial obesity surgery occurred prior to Coverage under this plan."

**RECONSTRUCTIVE SURGERY***

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Participating Provider physician determines that such surgery is necessary to improve function, or create a normal appearance, to the extent possible, including the following:
  - Blepharoplasty of upper lids
  - Breast reduction
  - Panniculectomy
  - Rhinoplasty
  - Septorhinoplasty
  - Surgical treatment of male gynecomastia
- Following Medically Necessary removal of all or part of a breast, reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services 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 Certificate for a description of applicable exceptions.

**TRANSPLANT SERVICES**

We cover transplants of organs, tissue, or bone marrow at participating transplant facilities if Molina Healthcare authorizes the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

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 Healthcare will only cover services You receive before that determination is made.
- Molina Healthcare is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.

- In accordance with Our guidelines for services for living transplant donors, Molina Healthcare provides certain donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. Covered Services 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) 560-4087.

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

**ORTHOGNATHIC SURGERY**

We cover orthognathic surgery services. Orthognathic surgery is the surgical treatment to restore the bones or other parts of the jaw to correct a congenital birth defect, the effect of an illness or injury or to correct other functional impairments.

Coverage is limited to the following:

- Referral care for evaluation and orthognathic treatment
- Cephalometric study and x-rays
- Orthognathic surgery and post-operative care, including hospitalization if necessary. Prior Authorization is required for these services.

For Covered Services related to orthognathic surgery, You will pay the Cost Sharing You would pay if the services were not related to orthognathic surgery. For example, see "Inpatient Hospital Services" in the Schedule of Benefits for the Cost Sharing that applies for hospital inpatient care.

## 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 Molina's Pharmacy Department
- They are ordered or given while You are in an emergency room or hospital
- They are given while You are in a skilled nursing facility and are 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 for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer 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 Which Are Not Covered" and "Substituting a Formulary Generic Drug with a Non-Formulary Brand Drug" sections below.

Prescription drugs are covered outside 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) 560-4087 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 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 Molina Healthcare toll-free at 1 (888) 560-4087. You may view a list of pharmacies on Molina Healthcare's website MolinaMarketplace.com.

**Molina Healthcare Drug Formulary (List of Drugs)**

Molina Healthcare has a list of drugs that We will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community.

The group meets every 3 months to talk about the drugs that are in the Drug Formulary. They review new drugs and changes in health care, in order 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 and medical technology. They may also be added to the Drug Formulary when new drugs come on the market.

You can look at Our Drug Formulary on Our Molina Healthcare website at MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-4087, Monday through Friday, 8:00 a.m. through 5:00 p.m. ET. If You are deaf or hard of hearing, call toll-free 1 (888) 665-4629 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.

**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.

If Your doctor prescribes a drug that is not listed on the Drug Formulary, they must submit a Prior

Authorization request to Molina Healthcare'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 Prior Authorization is obtained from Molina, We will contact Your doctor. You may purchase the drug at the Cost Sharing for Tier-3 or Tier-4 drugs listed on the Schedule of Benefits.

If the request is approved, Molina Healthcare will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor stating why the drug was denied.

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug.

The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You**.**

Molina Healthcare 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.

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 IRO review. You and/or Your Participating Provider will be notified of the IRO's decision no later than:

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

**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 unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, is not subject to Cost Sharing. Your Cost Sharing for a covered drug will not be more than the price that We have negotiated to pay for the drug, or Molina's allowed amount for the cost of the drug.

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

Lower-cost 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. 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.

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

Preferred 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. Preferred 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 Healthcare and Our pharmacy benefit manager.

**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 Healthcare 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. Formulary non-preferred 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 Healthcare and Our pharmacy benefit manager.

**Tier-4: Generic and Brand Name Specialty Drugs**

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

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

- Are only approved to treat limited patient populations, indications or conditions, including but not limited to growth hormone injections and drugs for treatment of infertility; 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 may require that Specialty drugs be obtained from a Participating Provider specialty pharmacy or facility for coverage. Our specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office.

We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications. The maximum Cost Share for an orally administered anti-cancer medication is [insert applicable dollar amount] for up to a 30 day supply and is not subject to a deductible.

**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 Preventative drugs may include Generic or Brand Name drugs.

**Substituting a Formulary Generic Drug with a Non-Formulary Brand Drug**

If Your doctor prescribes a brand name drug that is not in the Drug Formulary instead of a formulary generic drug, they must submit a Prior Authorization request to Molina Healthcare's Pharmacy department.

- If Prior Authorization is not obtained from Molina, We will send a letter to You and Your doctor stating why the drug was denied. You may purchase the brand name drug at the full cost charged by the pharmacy.
- If Prior Authorization is obtained from Molina, We will contact Your doctor. You may purchase the brand name drug at the following Cost Sharing:
    - The Cost Sharing for Tier-3 or Tier 4 drugs listed on the Schedule of Benefits, plus
    - The difference in cost between the formulary generic drug and brand name drug.

**Over-the-Counter 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

**Stop-Smoking Drugs**

We cover drugs to help You stop smoking. You will have no Cost Sharing for stop smoking drugs. You can also learn more about Your stop-smoking options by calling Molina Healthcare's Health Management Level 1 Programs Department toll-free at 1 (866) 472-9483, between 9:00 a.m. and 9:00 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.

**Cancer Drug Therapy**

As required by state law, drugs for cancer therapy and reasonable costs for administering them are covered. These drugs are covered regardless of whether the federal FDA has approved the cancer drug to be used for the type of tumor for which the drugs are being used.

**Diabetic Supplies**

Diabetic supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, blood glucose test strips and urine test strips are covered supplies. 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.

# ANCILLARY SERVICES

## DURABLE MEDICAL EQUIPMENT

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

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

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

We cover the following Durable Medical Equipment 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.

## 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 Healthcare selects

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

**Internally Implanted Devices**

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseo-integrated 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 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 and up to three brassieres every 12 months when required to hold a prosthesis
- 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 (DME Cost Sharing Applies)
- 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 they are Medically Necessary and approved by Molina. Such services are health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness and include:

- 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

You must have Prior Authorization for home healthcare services after the first 6 visits for outpatient and home settings. Services must be billed by a Home Healthcare Participating Provider agency

Home healthcare Covered Services do not include Rehabilitative Medicine Services.

### TRANSPORTATION SERVICES

#### Emergency Medical Transportation

We cover Emergency medical transportation (ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary. These services are covered only when other types of transportation 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 the lesser of Molina's Allowed Amount or an agreed upon rate for such services. Please note: 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.

#### 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 the lesser of Molina's Allowed Amount or an agreed upon rate for such services. Please note: You may be responsible for provider charges that exceed the allowed amount covered under this benefit for services rendered by a Non-Participating Provider.

### 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 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 Healthcare.
- You or a Participating Provider notifies Molina before services are provided. (Prior Authorization is not required.)

### DIABETES EDUCATION

As required by state law, We cover diabetes educational classes to ensure that a person with diabetes is trained as to the proper self-management and treatment of their diabetic condition.

### WEIGHT LOSS SERVICES

We cover physician-supervised weight loss programs that We have reviewed and approved or as outlined in Our medical policies.

**DIETITIAN SERVICES**

We cover consultation with a Participating Provider dietitian up to a maximum of 6 visits per calendar year.

**EYE CARE TREATMENT**

We cover medical treatment for medical conditions and diseases of the eye.

Except for those Covered Services listed in this section and under "Pediatric Vision Services" in the "What is Covered Under My Plan" section, We do not cover the following:

- Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses
- Eye exercises, visual training, orthoptics, sensory integration therapy
- Radial keratotomy, laser surgeries, and other refractive keratoplasties
- Refractions (tests to determine if eyeglasses are needed, and if so, what prescription)

# EXCLUSIONS

**What is Excluded from Coverage Under My Plan?**

This "Exclusions" section lists items and services excluded from coverage under this Certificate. These exclusions apply to all services that would otherwise be covered under this Certificate 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.

**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 medical coverage, life coverage or licensing, or
- On court order or required for parole or probation.

**Chiropractic Services**

Chiropractic services and the services of a chiropractor are not covered, except when provided in connection with occupational therapy and physical therapy.

**Cosmetic Services**

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

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

**Custodial Care**

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine) is not covered.

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

**Dental and Orthodontic Services**

Dental and orthodontic services are not covered, such as: X-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment, such as surgery on the jawbone and radiation treatment.

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

**Dietitian**

A service of a Dietitian is not a covered service except for 6 visits under the section of Dietician Services or for Hospice Care benefits please see both sections for additional information.

**Disposable Supplies**

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace- type bandages, and diapers, underpads, and other incontinence supplies are not covered.

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

**Erectile Dysfunction Drugs**

We do not cover drugs for erectile dysfunction unless required by state law.

**Experimental or Investigational Services**

Any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services 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 "How to File an External Review Request" section for information about independent medical review 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.

**Homeopathic and Holistic Services**

Acupuncture and other non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, massage therapy and Rolf therapy are not covered.

**Infertility Services**

All infertility services and supplies are not covered, except as covered in "What is Covered Under My Plan?" section, related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

**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," "Skilled Nursing Facility Care" and "Hospice Care" in the "What is Covered Under My Plan?" section.

**Items and Services that are Not Health Care Items and Services**

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

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

**Male Contraceptives**

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

**Massage Therapy**

Massage therapy is not covered.

**Non-Emergent Services Obtained in an Emergency Room**

Services provided within an emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

**Oral Nutrition**

Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food. This exclusion does not apply to Covered Services listed under "Food, Supplements, and Formula" in the "What's Covered Under My Plan" section.

**Private Duty Nursing**

Nursing services provided in a facility or private home, usually to one patient, are not covered. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a home healthcare agency.

**Reconstructive Surgery Exclusions**

The following reconstructive surgery services are not covered:

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

**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 Health Services" section, or
- a licensed facility providing transitional residential recovery services covered under the "Substance Abuse Services" section.

**Routine Foot Care Items and Services**

Routine foot care items and services that are not Medically Necessary are not covered.

**Services Not Approved by the FDA**

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require 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 U.S.

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 "How to File an External Review Request" section for information about independent medical review related to denied requests for Experimental or Investigational services.

**Services Performed by Unlicensed People**

Except as otherwise provided in this Certificate, services that are performed by people who do not require licenses or certificates by the state of Michigan 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 where 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, Specialist Physician 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 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 Healthcare 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 Healthcare would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply. Molina Healthcare would cover any services that We would otherwise cover to treat that complication.

**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**

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) 560-4087. You may also call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

**Vision Care Services**

Except for those Covered Services listed under "Pediatric Vision Services" and "Eye Care Treatment" in the "What is Covered Under My Plan" section, We do not cover the following:

- Eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses
- Eye exercises, visual training, orthoptics, sensory integration therapy
- Radial keratotomy, laser surgeries, and other refractive keratoplasties
- Refractions (tests to determine if eyeglasses are needed, and if so, what prescription)

# 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 Healthcare is entitled to reimbursement, then You shall:

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

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

## WORKERS' COMPENSATION

Molina Healthcare shall not furnish benefits under this Agreement 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 Healthcare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the workers' compensation carrier, as to Your ability to collect under workers' compensation laws, Molina Healthcare will provide the benefits described in this Agreement until resolution of the dispute.

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

## RENEWAL AND TERMINATION

**How Does my Molina Healthcare Coverage Renew?**

Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Renewal is subject to Molina Healthcare's right to amend this Certificate.

You must follow the procedures required by the Marketplace to redetermine Your eligibility and guaranteed renewability for enrollment every year during the Marketplace's annual open enrollment period.

**Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:**

Any change to this Agreement, including, but not limited to, changes in Premiums, or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina. The Marketplace determines your eligibility and advance premium tax credit.
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.

**Can Molina Cancel My Membership?**

Molina can terminate Your coverage only for the following reasons:

- For non-payment of premium (after grace period)
- If you commit fraud or intentional misrepresentation of material fact
- If the plan is terminated or decertified
- If You choose to change products in a manner permitted by the Marketplace
- If You are no longer eligible under the Marketplace
- If You cease to be a member of an association through which Your coverage was provided

If Molina terminates Your coverage for any reason other than non-payment of Premium or loss of eligibility. We will give You at least 30-days prior notice, and the notice will state the reason for the termination.

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

The termination date of Your coverage is the first day You are not covered with Molina Healthcare. For example, if Your termination date is July 1, 2017, Your last minute of coverage is at 11:59 p.m. on June 30, 2017.

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

Except in the case of fraud, 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. In the case of fraud, Molina may retain portions of this amount in order to recover losses due to the fraud.

Your membership with Molina Healthcare will terminate if You:

- **No Longer Meet Eligibility Requirements**
  Coverage under this Certificate will terminate if You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina Healthcare or the Marketplace. The Marketplace will send You notice of any eligibility determination. Molina Healthcare will send You notice of loss of eligibility when We learn You have moved out of the Service Area.
    - **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 Certificate, 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 is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)."
    - **For a Non-Dependent Member with Child-Only Coverage Reaching the Limiting Age,** Child-Only Coverage under this Certificate, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches the limiting age of 21. When Child-Only Coverage under this Certificate terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace.

- **Request Disenrollment**
  You decide to end Your membership and disenroll from Molina by notifying Molina and/or the Marketplace. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. At Our discretion, Molina may accommodate a request to end Your membership in fewer than 14 days.
- **Change the Marketplace Health Plans**
  You decide to change from Molina Healthcare to another health plan offered through the Marketplace in one of the following ways:
    - by timely cancelling Your coverage under this Certificate within 10 calendar days of delivery,
    - during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace's special enrollment procedures, or
    - when You seek to enroll a new Dependent.

  Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.
- **Commit Fraud or Intentionally Misrepresent Material Fact**
  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 Healthcare Member ID Card (or letting someone else use it).

  We will send a notice of termination to You, and Your membership will end at 11:59 p.m. on the 30th day from the date We mail the notice of termination. If Molina Healthcare terminates Your membership for cause, We may not allow You to enroll with Us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution. Rescission of coverage or eligibility is only allowed for fraud or intentional misrepresentation of material fact.
- **Discontinuation**
  If Molina Healthcare ceases to provide or arrange for the provision of health benefits for new or existing health care service plan contracts, in which case Molina Healthcare will provide You with written notice at least 180 days prior to discontinuation of those contracts.
- **Withdrawal of Product**
  Molina Healthcare withdraws this product from the market, in which case Molina Healthcare will provide You with written notice at least 90 days before the termination date.
- **Leaving the Marketplace**
  If Molina is terminated or decertified from the Marketplace.
- **Non-Payment of Premiums**
  If You do not pay required Premiums by the due date, Molina Healthcare may terminate Your coverage as further described in the "Premium Notices/Termination for Non-Payment of Premiums" section below.

Your coverage under certain Covered Service will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision Services covered under this Agreement. As a result, such Member's coverage under those specific Covered Service will terminate as of 11:59 p.m. on the last day of the month that the Member turns age 19, without affecting the remainder of this Certificate.

# PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

**Premium Notices/Termination for Non-Payment of Premiums**

Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the date stated on Your Premium bill. This is the "Due Date." Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Molina Healthcare does not receive the full Premium payment due on or before the Due Date, Molina Healthcare will send a notice of non-receipt of Premium payment and termination of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:
    - A statement that Molina Healthcare has not received full Premium payment and that We will terminate this Agreement for nonpayment if We do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
    - The amount of Premiums due.
    - The specific date and time when Your membership and any enrolled Dependents' membership 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 Healthcare will give a grace period to pay the full Premium payment as follows:

- **If You do <u>not</u> receive advance payment of the premium tax credit:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Molina will process payment for Covered Services received during the 31 day grace period. You will be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period.

- **If You receive advance payment of the premium tax credit:** A grace period of 3 months will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.
    - Molina will process payment for Covered Services received during the first month of the grace period. You will be responsible for any unpaid Premiums You owe Molina Healthcare for the first month of the grace period.
    - Molina will hold payment for Covered Services received after the first month of the grace period until We receive the delinquent Premiums. If Premiums are not received by the end of the 3-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.

**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.

**Reinstatement after Termination for Nonpayment of Premiums**

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 with Us.

**Termination Notice**: Upon termination of this Agreement, Molina Healthcare will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

# YOUR RIGHTS AND RESPONSIBILITIES

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

The rights and responsibilities below are also on the Molina Healthcare 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 Healthcare.
- Get information about Molina Healthcare, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor (Your PCP) from Molina's list of Participating Providers
- Be informed about Your health. If You have an illness, You have the right to hear 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 Healthcare or Your care. You can call, fax, e-mail, or write to Molina Healthcare's Customer Support Center.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina Healthcare (leave the Molina Healthcare product).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina Healthcare to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get information about Molina Healthcare, Your providers, or Your health in the language You prefer.

- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with applicable state laws.
- Receive instructions on how You can view online, or request a copy of, Molina Healthcare's non-proprietary clinical and administrative policies and procedures.
- Get a copy of Molina Healthcare's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina Healthcare's contracted hospitals.
- Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish, or seek revenge.
- File a grievance or complaint if You believe 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) 560-4087.
- Give Your doctor, provider, or Molina Healthcare 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 Healthcare card when getting medical care.
- Do not give Your card to others.
- Let Molina Healthcare 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 Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-4087, Monday through Friday, between 8:00 a.m. and 5:00 p.m. ET.

# MOLINA HEALTHCARE SERVICES

**Molina Healthcare is Always Improving Services**

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

If You would like to learn more about what We are doing to improve, please call Molina Healthcare toll-free at 1 (888) 560-4087 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 Certificate.

**New Technology**

Molina Healthcare is always looking for ways to take better care of Our Members. That is why Molina Healthcare 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 benefit for Molina Healthcare Members.

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

**What Do I Have to Pay For?**

Please refer to the "Schedule of Benefits" at the front of this Certificate for Your Cost Sharing responsibilities for Covered Services.

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

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

If Molina Healthcare 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.

**What if I have paid a Medical Bill or Prescription? (Reimbursement Provisions)**

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

After We receive Your letter, We will respond to You within 30 days. If Your claim is accepted, We will mail You a check. If not, We will send You a letter telling You why. If You do not agree with this, You may appeal by calling Molina Healthcare toll-free at 1 (888) 560-4087, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET.

**How Does Molina Healthcare Pay for My Care?**

Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers 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 Healthcare 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 Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-4087, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET. You may also call Your provider's office or Your provider's medical group for this information.

**How Long Does My Provider Have to File a Claim?**

Provider shall promptly submit to Molina Healthcare Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the Claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Claims must be submitted by Provider to Molina Healthcare within three-hundred sixty-five (365) calendar days after the following have occurred: discharge for inpatient services or the Date of Service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health maintenance organization. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina Healthcare within 30-45 calendar days after final determination by the primary payer. Except as otherwise provided by Law, any Claims that are not submitted to Molina Healthcare within these timelines shall not be eligible for payment and Provider hereby waives any right to payment therefore.

**What is the Processing Time for a Claim submitted by My Provider?**

Claims payment will be made to contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina Healthcare or contracted medical group/IPA have agreed in writing to an alternate payment schedule, Molina Healthcare will pay the Provider of service within 30-45 calendar days after receipt of Clean Claims.

The receipt date of a Claim is the date Molina Healthcare receives either written or electronic notice of the Claim.

**Advance Directives**

An Advance Directive is a form that tells medical providers what kind of care You want if You cannot speak for Yourself. An Advance Directive is written before You have an Emergency. This is a way to keep other people from making important health decisions for You if You are not well enough to make Your own.

A "Durable Power of Attorney for Health Care" and a "Natural Death Act Declaration" are types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives.

You may call Molina Healthcare to get information regarding State law on Advance Directives, and changes to Advance Directive laws. Molina Healthcare updates advanced directive information no later than 90 calendar days after receiving notice of changes to State laws.

For more information, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-4087. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

**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 is defined 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 called 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 state law 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, each of the parts is treated 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 be reduced 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, that 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 will be considered 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:

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

- A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

"**Closed Panel Plan**" is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers which have contracted with or are employed by the Plan, and that 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 is covered 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 coordination of benefits 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:

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 so that 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 is covered by 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 is given 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 and 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 of time 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**

A policy or certificate that contains a coordination of benefits provision shall provide that benefits under the policy or certificate shall not be reduced or otherwise limited because of the existence of another nongroup contract that is issued as a hospital indemnity, surgical indemnity, specified disease, or other policy of disability insurance as defined in section 3400 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being section 500.3400 of the Michigan Compiled Laws.

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 is enrolled 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**

Certain facts about health care coverage and services are needed 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, Your claim for benefits will be denied.

**Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated 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" section, below. If You are still not satisfied, You may call the Michigan Department of Insurance and Financial Services **DIFS** for instructions on filing a consumer complaint. Call 1 (**877) 999-6442** or visit the Department's website at https://difs.state.mi.us/Complaints/ExternalReview.aspx

# GRIEVANCES AND APPEALS

**What if I Have a Grievance or Complaint?**

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

- Call Molina Healthcare toll-free at 1 (888) 560-4087, Monday through Friday, 8:00 a.m. - 5:00 p.m. ET. Deaf or hard of hearing Members may call Our toll-free TTY number at 1 (888) 665-4629. You may also contact Us by calling the Telecommunications Relay Service at 711 if You are deaf or hard of hearing.
- You may also send Us Your problem or complaint in writing by mail or filing online at Our website.

Our address is:
Molina Healthcare
Grievances and Appeals Unit
880 West Long Lake Road
Troy, MI 48098
MolinaMarketplace.com

**Two Types of Grievances**

There are two types of grievances.

- An administrative grievance is a complaint or disagree You have with a Molina Healthcare decision relating to the availability, delivery, or quality of health care services.
- An Adverse Benefit Determination grievance is one where You disagree with an Adverse Benefit Determination made by Molina Healthcare.

The process for "Adverse Benefit Determination Grievance and Appeal Process," and "External Review Process" addressing a grievance depends on the type of grievance. The section immediately below described the Administrative Grievance Process. A description of the Adverse Benefit Determination Grievance and Appeal Process is in the section of this Certificate titled "Adverse Benefit Determination Grievance and Appeal Process."

For purposes of the "Administrative Grievance Process" section of this Certificate, the term "You" shall include Your authorized representative.

**ADMINISTRATIVE GRIEVANCE PROCESS**

You may submit Your administrative grievance to Molina Healthcare by:

- Calling Molina Healthcare toll-free at 1 (888) 560-4087, Monday through Friday, 8:00 a.m. - 5:00 p.m. ET. Deaf or hard of hearing Members may call Our toll-free TTY number at 1 (888) 665-4629. You may also contact Us by calling the Telecommunications Relay Service at 711 if You are deaf or hard of hearing.
- Sending Us Your administrative grievance in writing by mail or filing online at Our website.

Our address is:
Molina Healthcare
Grievances and Appeals Unit
880 West Long Lake Road
Troy, MI 48098
MolinaMarketplace.com

We will send You a letter acknowledging receipt of Your grievance within 5 calendar days and will then issue a formal response within 35 calendar days of the date of Your initial contact with Us.

If You are not satisfied with Our response to Your administrative grievance, You may file an appeal with Molina Healthcare if We can receive it and process it within 35 calendar days of the initial receipt of the administrative grievance. We will send You a letter acknowledging receipt of Your appeal within 5 calendar days. We complete all levels of Our grievances and appeal procedures within 35 calendar days. We may extend this period by up to 10 business days if We have requested and not received information from Your provider and You agree.

You must file Your grievance within 180 days from the day the incident or action occurred that caused You to be unhappy.

If Your administrative grievance involves an imminent and serious threat to Your health, Molina Healthcare will quickly review Your administrative grievance. Examples of imminent and serious threats include, but are not limited to, severe pain, potential loss of life, limb, or major bodily function. Molina Healthcare will issue a formal response no later than 72 hours. Within 10 days after receipt of formal response, You may request a review of Your grievance from the Michigan Department of Insurance and Financial Services.

If You are unhappy with Our final decision You may also a request with the Michigan Department of Insurance and Financial Services for an external review (sometimes also referred to as "independent review") of an Adverse Benefit Determination no later than **127**days after You receive the Final Adverse Benefit Determination notice from Molina.

For information on how to file a request please review to "**How to File an External Review Request" in this Agreement.**

**ADVERSE BENEFIT DETERMINATION GRIEVANCE AND APPEAL PROCESS**
**Definitions**

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

The term "Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit,

including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

The denial of payment for services or charges (in whole or in part) pursuant to Molina's contracts with Participating 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.

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

"Post-Service Claim" means We rendered an Adverse Benefit Determination for a service that completed.

"Pre-Service Claim" means We rendered an Adverse Benefit Determination and the requested service did not complete.

"Urgent Care Services Claim" means We rendered an Adverse Benefit Determination and the requested service did not complete, where the application of non-urgent care appeal periods 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 unless You receive 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. Your coverage will remain in effect pending the outcome of Your internal 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 you to do so to facilitate logging, identification, processing, and tracking of the appeal through the review process.

You may also request the clinical review criteria used to determine Medical Necessity in Your particular situation by contacting the Grievances and Appeals Coordinator at 1(888) 560-4087.

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

Molina Healthcare of Michigan, Inc.
Attention: Grievances and Appeals Coordinator
880 West Long Lake Road
Troy, MI 48098

Phone: 1 (888) 560-4087

If You are Hearing impaired You may also contact Molina via the Telecommunications Relay Service at 711. You or Your Authorized Representatives must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination.

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

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

| TIMEFRAME FOR RESPONDING TO APPEAL | |
|---|---|
| **REQUEST TYPES** | **TIMEFRAME FOR DECISION** |
| URGENT CARE SERVICE | WITHIN 72 HOURS. |
| PRE-SERVICEAUTHORIZATION | 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-SERVICEAUTHORIZATION | WITHIN 35 DAYS. |

**Exhaustion of Process**

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

**General Rules and Information**

General rules regarding Molina's Grievance 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, We will deem You to have waived Your right to have the Complaint or Appeal processed within the periods set forth above.

- Molina will offer to meet with You by telephone or in person. We will make appropriate arrangements to allow telephone conferencing or an in person meeting upon request at Our administrative offices. Molina will make these arrangements with no additional charge to You.

- During the review process, We will review the services in question 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 We made the initial Adverse Benefit Determination. 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 Grievances 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 grievances and appeals.

General Contact Information:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
PO Box 30220
Lansing, MI 48909-7720
https://difs.state.mi.us/Complaints/ExternalReview.aspx
Phone: 1 (877) 999-6442
Fax: 1 (517) 284-8838
www.michigan.gov/difs

Molina Healthcare of Michigan, Inc.
Customer Support Center
880 West Long Lake Road
Troy, MI 48098
Phone: 1 (888) 560-4087
MolinaMarketplace.com

Delivery Service:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th floor
Lansing, MI 48933-1521

**EXTERNAL REVIEW PROCESS**

You may request an external review of an Adverse Benefit Determination from the Michigan Department of Insurance and Financial Services only after exhausting the Molina Healthcare's internal review process described above unless:

(1) Molina Healthcare agrees to waive Our internal review process
(2) Molina Healthcare has not complied with the requirements of Our internal review process
(3) You request an expedited external review at the same time You request an expedited internal review

Your coverage will remain in effect pending the outcome of the external review.

**How to File an External Review Request**

You must file a request with the Michigan Department of Insurance and Financial Services for an external review (sometimes also referred to as "independent review") of an Adverse Benefit Determination no later than **127** days after You receive the Final Adverse Benefit Determination notice from Molina.

You must use the Health Care Request for External Review form to file the request that is available from either Molina Healthcare Customer Support Center at 1 (888) 560-4087 or write to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220,
Lansing, MI 48909-7720
1 (877) 999-6442
https://difs.state.mi.us/Complaints/ExternalReview.aspx
The external review request must contain an authorization for the necessary parties to obtain medical records for purposes of making a decision on the external review request.The external review decision is binding on Molina Healthcare and the Member except to the extent that other remedies are available under federal and state laws.

**Standard External Review**

Within 5 business days of receiving the Health Care Request for External Review form, the Director of the Department of Insurance and Financial Services (DIFS) will complete a preliminary review of the request to determine whether:

(a) the individual was a Member at the time of rescission or the health care service was requested or provided;
(b) the health care service that is the subject of the Adverse Benefit Determination is reasonably a covered service;
(c) the Member has exhausted Molina Healthcare's external review process described above;
(d) the Member has provided all the information and forms required for the external review; and
(e) the Adverse Benefit Determination involves issues of Medical Necessity or clinical review.

If the request is not complete, the Director of DIFS will inform You of what information or materials are needed to make the request complete.

If the request is not eligible for external review, the Director of DIFS will inform You in writing of the reasons why the request is not eligible for external review.

If a request is eligible for external review, the Director of DIFS will:

(1) notify Molina Healthcare of acceptance of the request for external review of an Adverse Benefit Determination; and

(2) notify You that the request has been accepted and that You may submit additional information within 7 business days of receipt of the Director of DIFS's notice.

If the Director of DIFS determines that the Adverse Benefit Determination involves an issue of Medical Necessity or clinical review criteria, the Director of DIFS will assign the request for external review to an approved independent review organization.

If the Adverse Benefit Determination does not involve issues of Medical Necessity or clinical review criteria, the Director of DIFS will conduct the review.

The independent review organization will provide its written recommendation to uphold or reverse the Adverse Benefit Determination to the Director of DIFS not later than 14 days after being assigned the request to review the Adverse Benefit Determination.

The Director of DIFS will notify You and Molina Healthcare of his or her decision to uphold or reverse the Adverse Benefit Decision within 7 business days after receiving the external review

organizations recommendation.

If the Director of DIFS conducts the review of the Adverse Benefit Determination because it does not involve issues of Medical Necessity or clinical review criteria, the Director of DIFS will notify You and Molina Healthcare of his or her decision within 14 business days after he or she makes the decision to conduct the review himself or herself.

If the Adverse Benefit Determination is reversed, Molina Healthcare will immediately approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due.

**Expedited External Review Requests**

You may request an expedited external review when:

(1) The Adverse Benefit Determination involves a medical condition that would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;
(2) You have filed a request for expedited internal review of the Adverse Benefit Determination with Molina Healthcare as described above; and
(3) You make the request for an expedited external review within 10 days of receiving the Adverse Benefit Determination.

Upon receipt of the Health Care Request for External Review form, the Director of DIFS will immediately send a copy of the request to Molina Healthcare.

If the Director of DIFS determines that the request to review an Adverse Benefit Determination involves an issue of Medical Necessity or clinical review criteria, he or she will assign the request for an expedited review to an independent review organization.

The independent review organization will decide immediately whether You will be required to first complete the expedited internal review process. If the independent review organization determines that You must complete the expedited internal review process it will immediately notify You.

The independent review organization will provide its recommendation of whether to uphold or reverse the Advance Benefit Determination as soon as expeditiously as the Member's medical condition or circumstances require, but in no event more than 36 hours after the date the Director of DIFS received the request for an expedited external review.

As expeditiously as the Member's medical condition or circumstances require, but in no event more than 24 hours after receiving the independent review organization's recommendation, the Director of DIFS will notify You and Molina Healthcare of the decision to uphold or reverse the Adverse Benefit Determination. If the notice is not in writing, the Director of DIFS will provide written confirmation of the decision to You and Molina Health care within 2 days after providing the original notice of his or her decision.

# OTHER

**MISCELLANEOUS PROVISIONS**

**Acts Beyond Molina Healthcare's Control**

A national disaster, war, riot, civil insurrection, epidemic or other similar event we cannot control may make our offices, personnel or financial resources unable to provide or arrange for the provision of Covered Services. If any of these events occur, We will not be liable if you do not receive those services in a prompt manner or if they are delayed. We will make every effort to ensure necessary services are provided as soon as possible under those circumstances,

**Waiver**

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

**Non-Discrimination**

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

If You think You have not been treated fairly please call the Customer Support Center toll-free at: 1 (888) 560-4087.

**Genetic Information**

Molina Healthcare will not collect genetic information from You for purpose of underwriting or otherwise. Molina Healthcare will not request or require You to take any genetic tests. Molina Healthcare will not adjust premiums or otherwise limit coverage based on genetic information.

**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 contacting the Secretary of State to obtain an organ donation card.

**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 Michigan law and any provision that is required to be in this Agreement by state or federal law shall bind Molina Healthcare and Members whether or not set forth in this Agreement.

**Invalidity**

If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall

remain operative and in full force and effect.

**Notices**

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

**Legal Action**

No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

**Time Limit on Certain Defenses**

After 3 years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by the applicant in the application for such Certificate shall be used to void the Certificate or to deny a claim for loss incurred or disability (as defined in the Certificate) commencing after the expiration of such 3-year period.

No claim for loss incurred or disability (as defined in the Certificate) commencing after 3 years from the date of issue of this Certificate shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Certificate.

**Proofs of Loss**

Written proof of loss must be furnished to Molina at its said office in case of claim for loss for which this Certificate provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which Molina is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

**Proof of Loss Claim Form**

Molina, upon receipt of a notice of claim, will furnish to You such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the Member shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**Proof of Loss Time of Payment of Claims**

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**Physical Examinations**

Molina at its own expense shall have the right and opportunity to examine the person of the Member when and as often as it may reasonably require during the pendency of a claim hereunder where it is not forbidden by law.

**Reinstatement**

If any renewal premium be not paid within the time granted Molina for payment, a subsequent acceptance of premium by Molina or by any agent duly authorized by Molina to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Certificate: Provided, however, That if Molina or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Molina or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless Molina has previously notified the Member in writing of its disapproval of such application.

The reinstated Certificate shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Member and Molina shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

**Wellness Program**

Your Agreement includes access to a health activities program. The goal of the program is to encourage You to complete health activities that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activities we encourage you to complete, are described below. For more information, please contact Member Services 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 Primary Care Provider, or an In-home health assessment exam facilitated through Molina.

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

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

You can also enroll in any of the programs above by calling the Molina Health Management Department at 1 (866) 891-2320 9:30 a.m. and 6:30 p.m. (MT), Monday through Friday.

**Newsletters**
Newsletters are posted on the www.MolinaHealthcare.com website at least 2 times a year. The articles are about topics asked by members like you. The tips can help you and your family stay healthy.

**Health Education Materials**
Our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, ask your doctor or visit our website at MolinaMarketplace/MPHealthEducation.

# Your Health Care Quick Reference Guide

| Department/ Program | Type of Help Needed | Number to Call/ Contact Information |
|---|---|---|
| **Molina Healthcare Customer Support Center Department** | If You have a problem with any of Molina Healthcare's services, We want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 a.m. to 5:00 p.m. ET. When in doubt, call Us first. | **Customer Support Center**<br>**Toll Free:** 1 (888) 560-4087<br>**TTY:** 1 (888) 665-4629 or dial 711 for the Michigan Relay Service |
| **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) | **Customer Support Center**<br>**Toll Free:** 1 (888) 560-4087<br>**TTY:** 1 (888) 665-4629 or dial 711 for the Michigan Relay Service |
| **Member Assessment/Health Education** | To request information on smoking cessation and weight management. | 1 (866) 472-9483<br>9:00 a.m. to 9:00 p.m. ET, Monday through Friday |
| **Nurse Advice Line** | If You have questions or concerns about Your health or Your family's health. The Nurse Advice Line is staffed by registered nurses. | 1 (888) 275-8750<br>24-Hours a day, seven days a week |
| **Motherhood Matters** | Molina Healthcare offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. | **Customer Support Center**<br>**Toll Free:** 1 (888) 560-4087<br>**TTY:** 1 (888) 665-4629 or dial 711 for the Michigan Relay Service |
| **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). | 1 (800) 368-1019<br>**TTY**: 1 (800) 537-7697<br>**Fax:** 1 (312) 886-1807 |
| **Medicare** | Medicare is health coverage 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<br>1 (800) 633-4227<br>TTY: 1 (877) 486-2048<br>**www.Medicare.gov** |
| **Michigan Department of Insurance and Financial Services** | The Michigan Department of Insurance and Financial Services is responsible for regulating health care services plans. If You have a grievance against Molina, You should first call Molina Healthcare toll-free at 1 (888) 560-4087, and use Molina Healthcare's grievance process before contacting this department. | Department of Insurance and Financial Services<br>P.O. Box 30220<br>Lansing. MI 48909-7720<br>1 (877) 999-6442<br>www.michigan.gov/difs |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