MOLINA MARKETPLACE

2014

Molina Healthcare of Texas, Inc. Agreement and Evidence of Coverage

Molina Marketplace – Silver 100 Plan

Texas

15115 Park Row
Suite 160
Houston, TX 77084

MOLINA® HEALTHCARE

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

MHT01012014001

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MHT01012014001

IMPORTANT NOTICE
To obtain information or make a complaint:

You may call Molina's toll-free telephone number for information or to make a complaint at:

1-888-560-2025 or

1-800-735-2989 TTY

You may also write to Molina at:

Member Complaints & Appeals
6999 McPherson, Suite 212
Laredo, TX 78041

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al:

1-888-560-2025 or

1-800-735-2989 TTY

Usted tambien puede escribir a Molina al:

Member Complaints & Appeals
6999 McPherson, Suite 212
Laredo, TX 78041

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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OTHER

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

This Agreement, amendments to this Agreement, and any application(s) submitted to Molina Healthcare and/or the Marketplace to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and together constitute the legally binding contract between Molina Healthcare and the Subscriber. Any change to this Agreement must be approved by an officer of Molina Healthcare and attached to this Agreement, and no agent has the authority to change the Agreement or waive any of its provisions.

WELCOME

Welcome to Molina Healthcare!

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

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

Molina Healthcare is a Texas licensed Health Maintenance Organization.

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

Molina Healthcare of Texas, Inc.
Customer Support Center
15115 Park Row, Suite 160
Houston, TX 77084
1 (888) 560-2025
www.molinahealthcare.com

If You are deaf or hard of hearing You may contact us through our dedicated TTY line, toll-free, at 1 (800) 735-2989 or by dialing 711 for the National Relay Service.

MOLINA HEALTHCARE OF TEXAS, INC.
SCHEDULE OF BENEFITS

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

Annual Out of Pocket Maximum	You Pay
Individual	$2,250
Entire Family of 2 or more	$4,500

Emergency Room and Urgent Care Services		You Pay
Emergency Room*	$100	Copayment per visit
Urgent Care	$15	Copayment per visit

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

Outpatient Professional Services**		You Pay
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$0	Copayment per visit
Specialty Care	$10	Copayment per visit
Other Practitioner Care	$10	Copayment per visit
Habilitative Services	10%	Coinsurance
Rehabilitative Services	10%	Coinsurance
Mental & Behavioral Health Services	$10	Copayment per visit
Substance Abuse/Chemical Dependency Services	$10	Copayment per visit
Pediatric Vision Services (for Members under Age 19 only)		
Vision Exam (screening and exam, limited to one exam each calendar year)	No Charge	
Prescription Glasses Standard Lenses (limited to 1 pair of prescription lenses every 12 months) Standard Frames (1 pair of frames every 12 months)	No Charge	

Standard Contact Lenses (limited to 1 pair every 12 months, in lieu of prescription glasses) as Medically Necessary for specified medical conditions	No Charge	
Low Vision Optical Devices and Services (subject to limitations and Prior Authorization applies)	10%	Coinsurance
Family Planning	No Charge	

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

Outpatient Hospital / Facility Services		**You Pay**
Outpatient Surgery		
Professional	10%	Coinsurance
Facility	10%	Coinsurance
Specialized Scanning Services		
CT Scan	10%	Coinsurance
PET Scan	10%	Coinsurance
MRI	10%	Coinsurance
Radiology Services	$10	Copayment
Laboratory Tests	$0	Copayment
Mental & Behavioral Health		
Outpatient Intensive Psychiatric Treatment Programs	10%	Coinsurance

Inpatient Hospital Services		**You Pay**
Medical / Surgical		
Professional	10%	Coinsurance
Facility	10%	Coinsurance
Maternity Care (professional and facility services)	10%	Coinsurance
Mental & Behavioral Health (Inpatient Psychiatric Hospitalization)	10%	Coinsurance
Substance Abuse/Chemical Dependency		
Inpatient Detoxification	10%	Coinsurance
Transitional Residential Recovery Services	10%	Coinsurance
Skilled Nursing Facility (limited to 25 days per calendar year)	10%	Coinsurance
Hospice Care	0%	Coinsurance

Prescription Drug Coverage		You Pay*
Formulary Generic Drugs	$3	Copayment
Formulary Preferred Brand Drugs	$8	Copayment
Formulary Non-Preferred Brand Drugs	10%	Coinsurance
Specialty Drugs (Oral and Injectable Drugs)	10%	Coinsurance

*** There are limits to the prescription drug cost-share you pay in certain circumstances. Please refer to Page 39 for more details and a description of prescription drug benefits.**

Ancillary Services		You Pay
Durable Medical Equipment	10%	Coinsurance
Home Health Care	$10	Copayment per visit
Emergency Medical Transportation (Ambulance)	$100	Copayment
Non-Emergency Medical and Non-Medical transportation (Combined limit 4 round trips per month)	$5	Copayment (Per round trip)

Other Services		You Pay
Dialysis Services	$10	Copayment

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.

This document is called Your "Molina Healthcare of Texas, Inc**.** Agreement and Evidence of Coverage (Your "Agreement" or "EOC"). The EOC tells You how You can get services through Molina Healthcare. It also sets out the terms and conditions of coverage under this Agreement, Your rights and responsibilities as a Molina Healthcare Member and how to contact Molina Healthcare. Please read this EOC completely and carefully. 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.

You have 10 days to examine this Agreement. Return it to us if You are not satisfied for any reason. We will refund premiums paid to You upon return of the Agreement. The Agreement will be considered to be void from the beginning. If any Covered Services have been rendered or claims paid by Molina Healthcare during the 10 days, You will be responsible for repaying Molina Healthcare for the services or claims.

Molina Healthcare is here to serve You.

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

Choose a doctor
Make an appointment
Arrange for an interpreter.

We can also listen and respond to Your questions (or complaints!) about Your benefits, Molina Healthcare, Your doctor, or any other Molina Healthcare services.

Call us toll-free at 1 (888) 560-2025 between 8:00 a.m. to 6:00 p.m. CT Monday through Friday. If You are deaf or hard of hearing, You may contact us through our dedicated TTY line toll-free at 1 (800) 735-2989. You can also dial 711 for the National Relay Service.

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

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

YOUR PRIVACY

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

Your Protected Health Information

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

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

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

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

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

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

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. **Our Notice of Privacy Practices is in the**

following section of this EOC. It is on our web site at www.molinahealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Customer Support Center. The number is 1-888-560-2025.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF TEXAS, 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 Texas, 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 includes referrals between Your doctors or other health care providers. For example, we may share information about Your health condition with a specialist. This helps the specialist talk about Your treatment with Your doctor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave 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 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 it private. We will follow reasonable requests if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

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

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

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

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

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

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Customer Support Center at 1-888-560-2025.

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

You may complain to us at:

Customer Support Center
15115 Park Row Suite 160
Houston, TX 77084
1-888-560-2025

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
1301 Young Street, Suite 1169
Dallas, TX 75202

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
15115 Park Row Suite 160
Houston, TX 77084
Phone: 1-888-560-2025

HELP FOR NON-ENGLISH SPEAKING MOLINA HEALTHCARE MEMBERS

Interpreter Services
As a Molina Healthcare Member, You have access to interpreter services. You have access 24 hour a day, seven (7) days a week. An interpreter request card is sent to all new Members after initial enrollment with Molina Healthcare.

You do not need to have a minor, friend or family member act as Your interpreter. You may wish to say things in private. Using an interpreter may be better for You. Please call the Customer Support Center toll-free at 1 (888) 560-2025.

How do You use the 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 to arrange for interpreter services by phone. 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) 560-2025

If You are deaf or hard of hearing You may contact us through our dedicated TTY line. The toll-free number is 1 (800) 735-2989. You may also dial 711 for the National Relay Service.

You can get help to understand this information in your language. Please call Molina Healthcare Customer Support at 1-(888) 560-2025.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

"**Emergency**" or "**Emergency Medical Condition**" means the recent 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, 3) serious dysfunction of any bodily organ or part; 4) serious disfigurement; or 5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"**Emergency Services**" mean health care services provided in a hospital emergency facility or department, freestanding emergency care facility, or a comparable facility to evaluate, stabilize or treat an Emergency Medical Condition, including screening services necessary to determine whether an emergency medical condition exists.

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

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

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

"**Experimental or Investigational**" means any medical service including treatment, procedures, equipment, medications, facilities, and devices not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time the services are provided, including, in the case of a drug, in the dosage to be used for the patient. Standard medical treatment means services or supplies that are in general use in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the hospital or other provider in which they were/will be performed; and
- the Participating Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of Molina Healthcare will determine whether any treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigational within this definition, and will consider the guidelines and practices of Medicare, Medicaid or other government-financed programs in making its determination. Although a physician may have prescribed the treatment, and the services or supplies may have been provided as the treatment of last resort, Molina Healthcare may still determine that such services or supplies are Experimental or Investigational within this definition. Treatment provided as part of a clinical trial or research study is Experimental or Investigational.

"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 Texas buy qualified health plan coverage from insurance companies or health plans such as Molina Healthcare. The Marketplace may be run as a state-based marketplace, a federally-facilitated marketplace or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of Texas, however, it may be organized and run.

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

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

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

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

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

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

"**Molina Healthcare of Texas, Inc. ("Molina Healthcare" or "Molina")**" means the corporation licensed by Texas as a Health Maintenance Organization, and contracted with the Marketplace. This EOC sometimes refers to Molina Healthcare as "we" or "our."

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

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

"**Other Practitioner**" refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

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

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

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

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

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

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

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this EOC, the term "**Spouse**" includes the Subscriber's common law spouse if the Subscriber and spouse are a couple who meet all of the requirements of Texas law and are Texas registered common law spouses, or the Subscriber's domestic partner in a domestic partnership registered in Travis County, Texas.

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

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

ELIGIBILITY AND ENROLLMENT

When will My Molina Healthcare Membership Begin?
Your coverage begins on the Effective Date. The Effective Date is:

- The date You meet all enrollment and Premium pre-payment requirements
- The date these are accepted by Molina Healthcare and/or the Marketplace.

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

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

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

If You fail to enroll during an open enrollment period, You may be able to enroll during a special enrollment period. Eligible for this is according to special enrollment procedures. These are established by the Marketplace. In such case, the Effective Date of coverage will be determined by the Marketplace. The Marketplace and Molina Healthcare will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

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

Who is Eligible?
You must meet all of the eligibility requirements established by the Marketplace. Check the Marketplace's website for eligibility criteria. This is true to enroll and stay enrolled. Molina Healthcare requires You to live or work in Molina Healthcare's Service Area for this product. If You have lost Your eligibility you may not be able to re-enroll. This is described in the section titled "When Will My Molina Healthcare Membership End? (Termination of Benefits and Coverage)."

Dependents: Subscribers who enroll in this product during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Molina

Healthcare requires Dependents to live or work in Molina Healthcare's Service Area for this product. The following types of family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren) and any child for whom the Subscriber must provide medical support under an Order issued under Chapter 154 of the Texas Family Code or enforceable by a court of Texas. Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren qualify as Dependents of the Subscriber only if the grandchild is unmarried, younger than 26 years of age and a dependent of the Subscriber for federal income tax purposes at the time application for coverage is made.

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

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

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

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina Healthcare, but not more frequently than annually following the two-year period when the information was first provided to Molina Healthcare.

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

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

- **Spouse**: You can add a Spouse as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:
    - The Spouse loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" in compliance with under the Affordable Care Act.
    - The date of Your marriage, common law marriage registration, or the date a Declaration of Domestic Partnership is filed with the County Clerk of Travis County, Texas.
    - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **Children Under 26 Years of Age:** You can add a Dependent under the age 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

- The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act;
- The child becomes a Dependent through marriage, common law marriage, or domestic partnership registration**,** birth, or adoption;
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.

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

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

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

- The date the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)," above, for more information.
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage, or termination of the domestic partnership from the Subscriber. However, the Dependent who loses coverage due to a change in marital status is eligible to have coverage issued separately to him or her with the same effective date as this Agreement. Please contact Molina Healthcare and/or the Marketplace for details.

MEMBER IDENTIFICATION CARD

How do I Know if I am a Molina Healthcare Member?
You get a Member identification (ID) card from Molina Healthcare. Your ID card comes in the mail. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call Molina Healthcare toll-free at 1 (888) 560-2025. 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) 560-2025.

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

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of Birth (DOB)
- Your Primary Care Doctor's name (Provider)

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

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

ACCESSING CARE

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

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

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

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

If You need hospital or similar services, You must go to a facility that is a Participating Provider. For more information about which facilities are with Molina Healthcare or where they are located, call Molina Healthcare toll-free at 1 (888) 560-2025. You may get Emergency Services or out of area Urgent Care Services in any emergency room or urgent care center, wherever located.

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

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
Emergency Care	Call 911 or go to the nearest emergency room. Even when outside Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	For directions, call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. For out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get 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 to get these services.
To see an OB/GYN (woman's doctor).	Women may go to any Participating Provider OB/GYN without a Referral or Prior Authorization. Ask Your doctor or call Molina Healthcare's Customer Support Center if You do not know an OB/GYN.
To see a specialist (for example, cancer or heart doctor)	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above
To have surgery	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above
To get a second opinion	Consult Your Provider Directory on our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate care center. You can also call Molina Healthcare's Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537. You also have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free 1 (888) 560-2025.

What is a Primary Care Provider?

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

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

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

If You want to know more about Your PCP or other Molina Healthcare doctors, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this product, Your health care services must be received from Molina Healthcare Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of Emergency Services or out of area Urgent Services. Please see page 22 for more information about the coverage of Emergency Services and out of area Urgent Services. If Medically Necessary Covered Services are not available through a Participating Provider, Molina Healthcare will allow a Referral to a non-Participating Provider, upon the request of Your Participating Provider, and will fully reimburse the non-Participating Provider at the usual and customary rate or at an agreed 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.molinahealthcare.com to view our online list of providers, or call Molina Healthcare toll-free at 1 (888) 560-2025 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 Your Provider Directory:

- Names
- Addresses, including zip codes
- Telephone numbers
- Languages spoken
- Availability of service locations

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

Note: Some hospitals and providers may not provide some of the services that may be covered under this EOC that You or Your family member might need. This includes family planning, birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should obtain more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 560-2025 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider?
It's easy to choose a Primary Care Provider (or PCP). Simply use our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for Yourself and another one for Your family members. If You have a chronic, disabling or life-threatening illness, You may want to ask Molina Healthcare to allow You to use a non-primary care specialist as Your PCP. Contact our Customer Support Center toll-free at 1 (888) 560-2025 to obtain the form to submit to Molina Healthcare. Molina Healthcare will approve or deny Your request within 30 days after receiving the written request. If the request is denied, You may appeal the denial through Molina Healthcare's complaint and appeal process.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is

important that You choose a PCP that You feel comfortable with. If You are female, You may, but are not required to, choose an OB/GYN (woman's doctor) to be Your PCP, and You may choose a pediatrician to be Your children's PCP.

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) 560-2025. Molina Healthcare can also help You find a PCP. Tell us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina Healthcare doctor.

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

Changing Your Doctor

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

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

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

How do I Change my Primary Care Provider?
Call Molina Healthcare toll-free at 1 (888) 560-2025, Monday through Friday, 8:00 a.m. to 6:00 p.m. CT. You may also visit Molina Healthcare's website at www.molinahealthcare.com to view our online list of Participating Providers. Let us help You make the change.

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

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

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

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

If You have been getting care from a doctor that is ending a contract with Molina Healthcare, You may have a right to keep the same doctor for a given time period. Please contact Molina Healthcare's Customer Support Center.

Continuity of Care Under Special Circumstances

If You are undergoing treatment for one of the conditions listed below and Your doctor is no longer a Participating Provider with Molina Healthcare, Your doctor may contact Molina Healthcare to request that You stay with the doctor You are now seeing for continuity of care due to special circumstances. Your doctor must also agree not to charge You for any amount that You would not have been responsible for paying if the provider had remained in the Molina Healthcare network.

The following conditions may be eligible for special circumstances continuation of care:

- You have a serious chronic condition or disability. "**Serious Chronic Condition**" means a medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that does either of the following:
    - Persists without full cure or worsens over an extended period of time.
    - Requires ongoing treatment to maintain remission or prevent getting worse.
- If You have a Serious Chronic Condition or disability, You may be able to stay with the doctor for up to 90 days following termination of the provider agreement.
- You are past the 24th week of pregnancy. Continuation of coverage may extend through the delivery of Your child and applies to immediate postpartum care and a follow-up check-up within the six-week period after delivery.
- You have a terminal illness. You may stay with the doctor or hospital for up to 9 months following termination of the provider agreement.

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

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

24-Hour Nurse Advice Line

If You have questions or concerns about You or Your family's health, call our 24-Hour Nurse Advice Line at 1 (888) 275-8750 or, for Spanish, at 1 (866)648-3537 or if You are deaf or hard of hearing access Nurse Advice with the National Relay Service by dialing 711. The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

Your doctor's office should give You an appointment for the listed visits in this time frame:

Appointment Type For PCPs	When You should get the appointment
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request
Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care
Non-urgent care with a non-physician behavioral health care provider appointments	Within two weeks of the appointment request
Appointment Type For Specialist Physicians	**When You should get the appointment**
Urgent care appointments for Covered Services requiring Prior Authorization	Within 24 hours of the appointment request
Urgent care appointments for Covered Services not requiring Prior Authorization	Within 24 hours of the appointment request

Routine or non-urgent care appointments	Within 3 weeks of the appointment request for medical care; within two weeks of the appointment request for behavioral health care

What is a Prior Authorization?

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

You do not need Prior Authorization for the following services:

- Emergency or Urgent Care Services
- Female Members may self-refer to an OB/GYN
- Family planning services
- Human Immunodeficiency Virus (HIV) testing & counseling
- Services for sexually transmitted diseases

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

- All inpatient admissions
- Cardiac and pulmonary rehabilitation
- Certain high dollar injectable drugs and medications not listed on the Molina Drug Formulary
- Cosmetic, plastic and reconstructive procedures
- Dental general anesthesia for dental restorations in Members 7 years old or older
- Dialysis – notification only
- Durable Medical Equipment that costs more than $500
- All customized orthotics / prosthetics and braces (for example special braces, shoes or shoe supports) wheelchairs (for example manual, electric or scooters) and internally implanted hearing devices
- Enteral formulas and nutritional supplements and related supplies
- Experimental and Investigational procedures
- Habilitative services
- Home health care
- Hospice inpatient care
- Imaging (special testing such as CT (computed tomography), MRI (magnetic resonance imaging), MRA (magnetic resonance angiogram), cardiac scan and PET (positron emission tomography) scan)
- Mental health services provided by Other Practitioners (i.e. other than Your Primary Care Physician or Specialist Physician (psychiatrist))
- Office based podiatry (foot) surgery
- Outpatient hospital / ambulatory surgery center procedures subject to exceptions*****
- Pain management services and procedures
- Pregnancy and delivery – notification only
- Rehabilitative services
- Specialty pharmacy provided by Other Practitioners (i.e. other than Your Primary Care Physician or Specialist Physician (psychiatrist))
- Substance abuse services
- Transplant evaluation and related services
- Transportation (non-emergent Medically Necessary ground and air ambulance, for example – medi-van, wheel chair van, ambulance, etc.)
- Any other services listed as requiring Prior Authorization in this EOC

*****Call Molina Healthcare's Customer Support Center at 1 (888) 560-2025 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 and Your provider decide to proceed with services that have been denied a Prior Authorization for benefits under this product, You may be responsible for the charges for the denied services.

Approvals are given based on medical need. If You have questions about how a certain service is approved, call Molina Healthcare toll-free at 1 (888) 560-2025. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 735-2989 or dial 711 for the National Relay Service. We will be happy to send You a general explanation of how that type of decision is made or send You a general explanation of the overall approval process if You request it.

You may call Molina Healthcare at 1 (888) 560-2025 to request Prior Authorization. Routine Prior Authorization requests will be processed within three calendar days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination. Medical conditions that may cause a serious threat to Your health and requests when the Member is an inpatient are processed within 24 hours from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina Healthcare processes requests for urgent specialty services immediately by telephone.

If a service is not Medically Necessary or is not a Covered Service, request for the service may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are also noted on pages 59 of this EOC.

Standing Approvals
If You have a condition or disease that requires specialized medical care over a prolonged period of time, You may need a standing approval. If You receive a standing approval to a specialist, You will not need to get a Referral or Prior Authorization every time You see that specialist. Also, if Your condition or disease is life threatening, worsening, or disabling, You may need to receive a standing approval to a specialist or specialty care center. They have the expertise to treat the condition or disease. To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina Healthcare's physicians and specialists to ensure You receive a treatment plan based on Your medical needs. If You have any difficulty getting a standing approval, call Molina Healthcare toll-free at 1 (888) 560-2025 or call our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 735-2989 or dial 711 for the National Relay Service. If, after calling the plan, You feel Your needs have not been met, please refer to Molina Healthcare's complaint process on page 57.

Second Opinions
You or Your PCP may want another doctor (a PCP or a specialist) to review Your condition. This doctor looks at Your medical record and may see You. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Provider Directory on our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.

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

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

- Your doctor has not answered Your concerns about Your diagnosis or plan of care.

Emergency and Urgent Care Services

What is an Emergency?
Emergency Services are health care services needed to evaluate, stabilize or treat an Emergency Medical Condition. An Emergency Medical Condition includes a medical or psychiatric medical condition having acute and severe symptoms (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, or if pregnant, the fetus' health in serious danger.
- Serious damage to bodily functions.
- Serious dysfunction or disfigurement of any bodily organ or part.

Emergency Services also includes Emergency contraceptive drug therapy.

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

How do I get Emergency care?

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

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

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

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

If You are not sure if You need Emergency health care but You need medical help, call Your PCP. Or call our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, in Spanish at 1 (866) 648-3537. The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please use the National Relay Service by dialing 711.

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

What if I'm away from Molina Healthcare's Service Area and I need Emergency health care?
Go to the nearest emergency room for care. Please contact Molina Healthcare within 24 hours, or when medically reasonable, of getting urgent or Emergency health care. Call toll-free at 1 (888) 560-2025. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 735-2989 or dial 711 for the National Relay Service. When You are away from Molina Healthcare's Service Area, only Urgent Care Services or Emergency Services are covered.

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

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

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

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

You have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free at 1 (888) 560-2025.

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

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

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

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

If You would like information about this program, please call the Customer Support Center toll free at 1(888) 560-2025 or call our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 735-2989 or dial 711 for the National Relay Service.

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

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

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

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits under this Agreement, You must pick an OB/GYN or nurse practitioner who is a Participating Provider. If You need help choosing an OB/GYN or if You have any questions, call Molina Healthcare toll-free at 1 (888) 560-2025, Monday through Friday from 8:00 a.m. to 6:00 p.m. CT. We will be happy to assist You.

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

Accessing Care for Members with Disabilities

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

Physical Access
Molina Healthcare has made every effort to ensure that our offices and the offices of Molina Healthcare doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at 1 (888) 560-2025 or call our dedicated TTY line toll-free at 1 (800) 735-2989 and a Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Let us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. It is our goal to have an interpreter meet You at the doctor's office. Call Molina Healthcare's Customer Support Center through our TTY Number toll-free at 1 (800) 735-2989, or dial 711 to use the National Relay Service.

Access for Persons with Low Vision or who are Blind
This EOC and other important plan materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available and this EOC is also available in an audio format. For accessible formats, or for direct help in reading the EOC and other materials, please call Molina Healthcare toll-free at 1 (888) 560-2025. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina Healthcare's Customer Support Center.

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

BENEFITS AND COVERAGE

Molina Healthcare covers the services described in the section titled "What is Covered Under My Plan?", below, subject to the exclusions, limitations, and reductions set forth in this EOC, 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 EOC
- 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 EOC – e.g., in the case of an Emergency or need for out-of-area Urgent Care Services.

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

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

Cost Sharing is the Copayment or Coinsurance that You must pay for Covered Services under this Agreement. The

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

YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF TEXAS, INC. SUMMARY OF BENEFITS CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

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

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

Coinsurance

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

Copayment

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

General Rules Applicable to Cost Sharing

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

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

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

- For items ordered in advance, You pay the Cost Sharing in effect on the order date (although Molina Healthcare

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

Receiving a Bill

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

How Your Coverage Satisfies the Affordable Care Act

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

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

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

Making Your Coverage More Affordable

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

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

WHAT IS COVERED UNDER MY PLAN?

This section tells You what medical services Molina Healthcare covers, also known as Your Benefits and Coverage or Covered Services. Covered Services include basic health care services as required under Texas laws as well as other medical services described in this EOC.

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

You have the right to appeal if a service is denied. Turn to page 61 for information on how You can have Your case

reviewed (see Independent Medical Review).

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Go to page 61 for information. Molina Healthcare also may cover routine medical costs for Members in Approved Clinical Trials. Go to page 37 to find out more.

Certain medical services described in this section will only be covered by Molina Healthcare if You obtain Prior Authorization ***before*** seeking treatment for such services. For a further explanation of Prior Authorization and a complete list of Covered Services which require Prior Authorization, go to page 20. However, Prior Authorization will never apply to treatment of Emergency Conditions or for Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

PREVENTIVE CARE AND SERVICES

Preventive Services and the Affordable Care Act

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

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

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

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

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

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

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

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

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

Preventive Care for Children and Adolescents

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

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

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

Preventive Care for Adults and Seniors

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

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Mammogram for women (based on Your age)
- Pap smear for women (based on Your age) and health status including human papilloma virus
- (HPV) screening test
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening

- Osteoporosis screening for women (based on Your age)
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health education
- Family planning services
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing exams and screenings
- Eye exams and preventive vision screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA screening, counseling about breast cancer preventive medication
- Chlamydial infection screening: women
- Depression screening: adults
- Healthy diet counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Tobacco use counseling and interventions
- Well-woman visits
- Screening and counseling for interpersonal and domestic violence: women

Preventive Care for Adults and Seniors includes a health risk assessment at least once every three years and, for women, an annual well-woman examination.

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 consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Clinical diagnoses of Alzheimer's Disease can be made by a Participating Provider that is a physician licensed in Texas.
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Medical screening for atherosclerosis and abnormal artery structure, once every 5 years performed by a certified laboratory, and including either CT scanning measuring coronary artery calcification or ultrasonography measuring carotid intima-media thickness and plaque. This screening is available for men who are 45 years of age or older and women who are 55 years of age or older; the Member must be either diabetic or have a high risk of developing coronary heart disease
- Physician care in or out of the hospital
- Consultations and well-child care, including necessary diagnostic follow-up care related to screening tests

- If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) who is a Participating Provider for routine examinations and prenatal care without a referral or Prior Authorization.
- Outpatient maternity care, including Medically Necessary supplies for a home birth; services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia; services of Other Practitioners, including a certified nurse midwife; and related laboratory services

HABILITATIVE SERVICES

We cover 35 visits per year for habilitative services, which are defined as health care services and devices that are designed to assist individuals acquiring, retaining or improving self-help, socialization, and adaptive skills and functioning necessary for performing routine activities of daily life successfully in their home and community based settings. These services may include physical therapy, occupational therapy, speech therapy, and durable medical equipment.

REHABILITATIVE SERVICES

We cover Medically Necessary rehabilitative services. These services help injured or disabled Members resume activities of daily living. This means services such as physical therapy, speech therapy and occupational therapy. These would occur in the right setting for the level of disability or injury. Medically Necessary covered rehabilitative services will not be denied, limited, or terminated if the therapy or service meets or exceeds Your treatment goals. This benefit includes up to 35 visits per year with a chiropractor. The chiropractor must provide services in connection with outpatient rehabilitation, occupational therapy and physical therapy.

OUTPATIENT MENTAL AND BEHAVIORAL HEALTH SERVICES

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

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

We cover outpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current Edition, 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**" 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.

Molina Healthcare covers the screening, diagnosis and treatment of Autism Spectrum Disorder only as provided in this Agreement under (1) "Preventive Care for Children and Adolescents" in the "Preventive Services and the Affordable Care Act" section above, and (2) the "Outpatient Autism Spectrum Disorder Services" section below.

OUTPATIENT AUTISM SPECTRUM DISORDER SERVICES

We cover treatment and services to Members under the age of 10 for all generally recognized services prescribed in relation to autism spectrum disorder by the Member's PCP in the treatment plan recommended by that physician. These services include, but are not limited to:

- evaluation and assessment services;

- applied behavior analysis as defined in Texas insurance regulations;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

The services must be provided by a Participating Provider or Other Practitioner who is licensed, certified or registered by an appropriate agency of Texas. Their professional credentials must be recognized and accepted by an appropriate agency of the United States, or certified as a provider under the TRICARE military health system. All Covered Services are subject to the Cost Sharing requirements for Outpatient Professional Services.

After the Member reaches age ten, the Benefits and Coverage as otherwise available under this Agreement will be available to the Member. All provisions of this Agreement will apply including, but not limited to, defined terms, limitations and exclusions, Prior Authorization and any applicable benefit maximums.

OUTPATIENT SUBSTANCE ABUSE/CHEMICAL DEPENDENCY SERVICES

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

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

We cover substance abuse/chemical dependency under this policy. We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Outpatient Substance Abuse/Chemical Dependency Services" section.

DENTAL AND ORTHODONTIC SERVICES

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

Dental Services for Radiation Treatment
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for treatment. This includes radiation therapy of cancer or neoplastic disease in Your head or neck. A Participating Provider physician must provide the services. Molina Healthcare may authorize a Referral to a dentist.

Dental Trauma
We cover services provided to correct damage to healthy, unrestored natural teeth and supportive tissues. These services will correct damage caused solely by external, violent accidental injury. Services are limited to treatment provided within 24 months of the initial treatment. An injury as the result of biting or chewing shall not be considered to be an accidental injury.

Dental Anesthesia
For dental procedures, we cover general anesthesia and the Participating Provider facility's services associated with the anesthesia. All of the following must be true:

- You are under age 7, or You are developmentally disabled, or Your health is compromised
- The dental procedure must be provided in a hospital or outpatient surgery center because of clinical status or

existing medical condition
- 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 needed to prepare the mouth for an extraction, and orthodontic services. You must meet all of these requirements:

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

PEDIATRIC DENTAL SERVICES

Pediatric dental services may be separately provided through a stand-alone dental plan that is certified by the Marketplace. Pediatric dental services are not covered under this product.

PEDIATRIC VISION SERVICES

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

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

Laser corrective surgery is not covered.

Please refer to the Molina Healthcare of Texas, Inc. Summary of Benefits for limitations and Cost Sharing

TREATMENT FOR ACQUIRED BRAIN INJURY

We cover treatment for Medically Necessary services for an Acquired Brain Injury on the same basis as treatment for other physical conditions. Cognitive rehabilitation and communication therapies, neurocognitive therapy and rehabilitation neurobehavioral, neuropsychological, neurophysiological and neuropsychological testing and treatment; neurofeedback therapy, remediation, post-acute transition and community integration services, including outpatient day treatment services, or any other post-acute treatment services are covered. Such services must be necessary as a result of and related to an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate treatment or therapies may be provided. Covered Services include reasonable expenses for periodic reevaluation of the care of a Member who has incurred an Acquired Brain Injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Treatment goals may include the maintenance of function or the prevention or slowing of deterioration.

FAMILY PLANNING

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

- Health education and counseling to help You make informed choices and to understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated. This is to help you decide what birth control methods to use.
- Prescription birth control supplies and devices.
- Birth control pills, including Depo-Provera.
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers.
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency.
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Pregnancy testing and counseling.
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated.
- Screening, testing and counseling of at-risk individuals for HIV. Referral for treatment.

PREGNANCY TERMINATIONS

Molina Healthcare covers pregnancy termination services. There are certain coverage restrictions required by the Affordable Care Act and by any applicable laws in the State of Texas.

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

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

Office Visit and Outpatient Surgery Cost Sharing will apply.

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

COVERAGE FOR CERTAIN AMINO-ACID BASED ELEMENTAL FORMULAS

We cover Medically Necessary amino acid-based elemental formulas. This is regardless of the formula delivery system. They must be used for the diagnosis and treatment of:

1) immunoglobin E and non-immunoglobin E mediated allergies to multiple food proteins;
2) severe food protein-induced enterocolitis syndrome;
3) eosinophilic disorders, as evidenced by the results of a biopsy; and
4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

The coverage includes any Medically Necessary services associated with the administration of the formula. It is subject to the written order of a Participating Provider. It must be for the treatment of a Member who is diagnosed with one of the above listed conditions. Coverage for formulas and special food products is provided on the same basis as any other prescription medication under this plan.

PHENYLKETONURIA (PKU)

We cover testing and treatment of phenylketonuria (PKU). This includes Medically Necessary services associated

with the administration of formulas and special food products. The regimen must be prescribed by a physician and managed by a licensed health care professional in consultation with a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.
For purposes of this section, the following definitions apply:

"Formula" is an enteral product for use at home that is prescribed by a physician.

"Special food product" is a food product that is prescribed by a physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

(Prescription Drug Cost Sharing will apply)

OUTPATIENT HOSPITAL/FACILITY SERVICES

OUTPATIENT SURGERY

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

OUTPATIENT PROCEDURES (OTHER THAN SURGERY)

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

SPECIALIZED SCANNING SERVICES

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

RADIOLOGY SERVICES

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

RADIATION THERAPY

We cover radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

LABORATORY TESTS

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

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

pregnancy
- Alpha-Fetoprotein (AFP) screening

MENTAL HEALTH AND BEHAVIORAL HEALTH
OUTPATIENT INTENSIVE PSYCHIATRIC TREATMENT PROGRAMS

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

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric day treatment program
- Short-term treatment in a residential treatment center or crisis stabilization program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis on the same basis as if the patient was an inpatient in a hospital
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL SERVICES

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

MEDICAL/SURGICAL SERVICES

We cover the following inpatient services in a Participating Provider hospital, when the services are generally and customarily provided by acute care general hospitals inside our Service Area:
- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our Drug Formulary guidelines. For discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section.
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections. Inpatient hospital care is covered for a minimum of 48 hours following a mastectomy and 24 hours following lymph node dissections.
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy. This includes treatment in an organized, multidisciplinary rehabilitation program.
- Respiratory therapy
- Medical social services and discharge planning
- Prescribed biologicals
- Special diets when Medically Necessary

MATERNITY CARE

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

- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require Prior Authorization from Molina Healthcare in consultation with Your

physician. Inpatient Hospital Services Maternity Cost Sharing will apply.

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

MENTAL AND BEHAVIORAL HEALTH
INPATIENT PSYCHIATRIC HOSPITALIZATION

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

We cover inpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 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**" 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.

Molina Healthcare covers the screening, diagnosis and treatment of Autism Spectrum Disorder only as provided in this Agreement under (1) "Preventive Care for Children and Adolescents" in the "Preventive Services and the Affordable Care Act" section above, and (2) the "Outpatient Autism Spectrum Disorder Services" section above.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY
INPATIENT DETOXIFICATION

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

- Room and board
- Participating Provider physician services
- Medication
- Dependency recovery services, education, and counseling.

We cover for substance abuse/chemical dependency under this policy.

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY
TRANSITIONAL RESIDENTIAL RECOVERY SERVICES

We cover substance abuse treatment in a nonmedical transitional residential recovery setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment. Coverage for substance abuse/chemical dependency under this policy is limited to three separate series of treatment for each covered individual.

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
- Medication
- Injections

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

The SNF benefit is limited to 25 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
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services
- Physician services
- Medication
- 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. This must be for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

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

APPROVED CLINICAL TRIALS

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

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

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. It is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. One of the following must be true:

(1) the study is approved or funded by one or more of the following:
   a. The National Institutes of Health, the Centers for Disease Control and Prevention,
   b. The Agency for Health Care Research and Quality,
   c. The Centers for Medicare and Medicaid Services,

d. The U.S. Department of Defense, the U.S. Department of Veterans Affairs,
e. The U.S. Department of Energy, or
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

or

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

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

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.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit or place conditions on its coverage of Your routine patient costs associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this EOC based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to members in the clinical trial.

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

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

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

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects. This includes craniofacial abnormalities of a child, developmental abnormalities, trauma, infection, tumors, or disease, if a Participating Provider physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, Molina Healthcare covers reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Breast reconstruction is a Covered Service even if the mastectomy occurred prior to Your Effective Date of coverage.

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services are not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of Texas, Inc. Summary of Benefits.

Reconstructive surgery exclusions

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

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

Transplant Services

We cover transplants of organs, tissue, or bone marrow at participating transplant facilities. A Participating Provider physician must provide a written Referral for care to a transplant facility. Molina Healthcare must authorize the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?".

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

- The physician or the referral facility may determine that You do not satisfy its respective criteria for a transplant. Molina Healthcare will only cover services You receive before that determination is made.
- Molina Healthcare is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with our guidelines for services for living transplant donors, Molina Healthcare provides certain donation-related services for a donor, or an individual identified as a potential donor. This applies whether or not the donor is a Member. These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling our Customer Support Center toll-free at 1 (888) 560-2025.

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

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

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

We cover brand name drugs, generic drugs and specialty drugs when such prescription drugs are obtained through Molina Healthcare's contracted pharmacies within Texas.

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

If You have trouble getting a prescription filled at the pharmacy, please call Molina Healthcare's Customer Support

Center toll-free at 1 (888) 560-2025 for assistance. If You are deaf or hard of hearing, call our dedicated TTY line toll-free at 1 (800) 735-2989. You can contact us with the National Relay Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 560-2025. You may view a list of pharmacies on Molina Healthcare's website, www.molinahealthcare.com.

Molina Healthcare Drug Formulary (List of Drugs)
Molina Healthcare has a list of drugs that it will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. The group meets every three (3) months to talk about the drugs that are in the formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added or taken off the Drug Formulary based on changes in medical practice, medical technology, and when new drugs come on the market.

You can look at our Drug Formulary on our Molina Healthcare website at www.molinahealthcare.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-2025. We are open Monday through Friday, 8:00 a.m. through 6:00 p.m. CT. If You are deaf or hard of hearing, call toll-free 1 (800) 735-2989. You may also dial 711 for the National Relay Service. You can also ask us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Access to Drugs Which Are Not Covered

Molina does have a process to allow You to request and gain access to clinically appropriate drugs that are not covered under your product. If Your doctor orders a drug that is not listed in the Drug Formulary or is an off-label use of a drug that he or she feels is best for You, Your doctor may make a request that Molina cover the drug for You. This would happen through Molina Healthcare's Pharmacy Department. If the request is approved, Molina Healthcare will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor stating why the drug was denied. You may appeal a denial of a drug request as an Adverse Benefit Determination. See the Complaints and Appeals section for more information.

If Molina removes a drug from the Drug Formulary after Your Effective Date of coverage under this Agreement, Molina will continue to cover the drug for You until the next January 1. In order for the drug to be covered, the drug must be Medically Necessary and You must meet the other requirements of this EOC, including Prior Authorization.

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

Molina will cover off-label use of a drug to treat You for a covered chronic, disabling, or life-threatening illness if the drug (1) has been approved by the FDA for at least one indication, and (2) is recognized as an effective drug for treatment of the indication in any standard drug reference compendium or any substantially accepted peer-reviewed medical literature Off-label drug use must be Medically Necessary to treat Your covered condition, and must be Prior Authorized. We will not deny coverage of off-label drug use solely on the basis that the drug is not on the Drug Formulary.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of Texas, Inc. Summary

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, 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 the usual and customary cost of the drug.

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

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

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

Brand Name Drugs
Brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by its manufacturer and are advertised and sold under that name. They are indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and our pharmacy benefit manager. If You receive a brand name drug when a generic drug is available, Your Cost Sharing for the drug will be no more than the generic drug Copayment plus the difference between the cost of the generic drug and the cost of the brand name drug.

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

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or
- Require additional patient support

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

Orally Administered Anti-Cancer Medications
We cover Medically Necessary orally administered anti-cancer medications that are used to kill or slow the growth of cancerous cells. Specialty Oral and Injectable Drug Cost Sharing amounts apply to orally administered anti-cancer medications listed on the Molina Healthcare Drug Formulary.

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

Diabetes Supplies
Diabetes supplies are covered. This includes:

- Insulin
- Syringes
- Glucometers
- Glucagon emergency kits
- Blood glucose test strips

- Urine test strips

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

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT

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

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

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

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

- Blood glucose monitors and blood glucose testing strips
- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes related foot problems
- Insulin syringes
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover some internally implanted devices and external devices. All of the following requirements must be met:

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

When we do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a

prosthetic or orthotic device. If we cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices

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

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

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Prostheses used to replace a missing part (such as a hand, arm or leg) that are needed to alleviate or correct illness, injury or congenital defects, including orthopedic braces (not orthodontic braces) used to support, align or hold bodily parts in a correct position, and rigid back, neck or leg braces; special surgical and back corsets and trusses and splints which are custom designed for the purpose of assisting the function of the joint; limited to medically appropriate equipment and subject to Prior Authorization. Repair or replacement of such prostheses is a Covered Service only when Medically Necessary and subject to Prior Authorization

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

HOME HEALTHCARE

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

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

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

- Up to two hours per visit for visits by a nurse, medical social worker, physician, occupational, or speech therapist and up to four hours per visit by a home health aide

- Up to three visits per day (counting all home health visits)
- Up to 60 visits per calendar year (counting all home health visits)

You must have approval for all home health services before the service begins.

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

TRANSPORTATION SERVICES

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

Non-Emergency Medical Transportation
We cover non-Emergency medical transportation to medical facilities when Your medical and physical condition does not allow You to take regular means of public or private transportation (car, bus, air, etc.). This requires that You also have a written prescription from Your doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. You must have Prior Authorization from Molina Healthcare for these services before the services are given. Please review the Molina Healthcare or Texas, Inc. Schedule of Benefits to determine applicability of this benefit to Your product.

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

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

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

HEARING SERVICES

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

We do cover the following:

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

OTHER SERVICES

DIALYSIS SERVICES

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

- The services are provided inside our Service Area
- You satisfy all medical criteria developed by Molina Healthcare.

- A Participating Provider physician provides a written Referral for care at the facility

DIABETES MANAGEMENT SERVICES

We cover expenses for the nutritional, educational, and psychosocial treatment of the Qualified Member. Such Diabetes Management Services/Diabetes Self—Management Training for which a physician or Other Participating Provider has written an order to the Member or caretaker of the Member is limited to the following when rendered by or under the direction of a Participating Physician.

Initial and follow-up instruction concerning:

(1) The physical cause and process of diabetes;

(2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

(3) Prevention and treatment of special health problems for the diabetic patient;

(4) Adjustment to lifestyle modifications; and

(5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the Qualified Member includes the development of an individualized management plan. This is created for the Qualified Member and family to understand the care and management of diabetes. This includes nutritional counseling and proper use of diabetes equipment and supplies.

A Qualified Member under this plan has been diagnosed with:
(a) insulin dependent or non-insulin dependent diabetes
(b) elevated blood glucose levels induced by pregnancy
(c) another medical condition associated with elevated blood glucose levels.

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

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

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

Submit Your claims for reimbursement for Covered Services to:

Molina Healthcare
PO Box 22719
Long Beach, CA 90801

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

Please see page 56-57 of this EOC for additional details regarding how Molina Healthcare processes claims from Members.

EXCLUSIONS

What is Excluded from Coverage Under My Plan?

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

Acupuncture

Acupuncture services or supplies are not covered.

Artificial Insemination and Conception by Artificial Means

All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Bariatric Surgery

Bariatric surgery is not covered. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an inpatient stay or an extended inpatient stay for the bariatric surgery, as determined by Molina, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Molina plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Agreement. Directly related means that the inpatient stay or extended inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

Certain Exams and Services

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

Chiropractic Services

Chiropractic services and the services of a chiropractor, except as described in the REHABILITATIVE SERVICES benefit.

Cosmetic Services

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

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

Custodial Care

Assistance with activities of daily living. Examples include walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine.

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

Dental and Orthodontic Services

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

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

Disposable Supplies

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

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

Experimental or Investigational Services

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

This exclusion does not apply to any of the following:

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

Please refer to the "Independent Medical Review" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Hair Loss or Growth Treatment

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

Infertility Services
Services related to treatment of infertility are not covered. This exclusion does not apply to Covered Services for the diagnosis of infertility.

Intermediate Care

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

Items and Services That are Not Health Care Items and Services

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

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

Items and Services to Correct Refractive Defects of the Eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Massage Therapy

Massage therapy is not covered.

Oral Nutrition

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

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed for the treatment of Phenylketonuria, in accordance with the "Phenylketonuria (PKU)" section of this EOC.

Private Duty Nursing

Private duty nursing services are not covered.

Residential Care

Care in a facility where You stay overnight. This exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental 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.

Services Not Approved by the Federal Food and Drug Administration

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

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 "Independent Medical Review for Denials of Experimental/Investigational Therapies" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People

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

Services Related to a Non-Covered Service

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

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Transgender Surgery

Transgender surgeries are not covered.

Travel and Lodging Expenses

Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from our Customer Support Center by calling toll free at 1(888) 560-2025. You may call our dedicated TTY for the deaf or hard of hearing toll-free at (800) 735-2989. You may dial 711 for the National Relay Service.

Services Provided Outside the United States (or Service Area)

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

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

THIRD-PARTY LIABILITY

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

- Reimburse Molina Healthcare for the reasonable cost of services paid by Molina Healthcare to the extent permitted by Texas law immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Molina Healthcare's effectuation of its lien rights for the reasonable value of services provided by Molina Healthcare to the extent permitted under Texas 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 (recover benefits paid when other insurance provides coverage) in third party recoveries. You shall cooperate to fully and completely assist in protecting the rights of Molina Healthcare including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

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

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

RENEWAL AND TERMINATION

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

Changes in Premiums, Copayments and Benefits and Coverage:
Any change to this Agreement is effective after 60 days' notice to the Subscriber's address of record with Molina Healthcare. This includes changes in Premiums, Benefits and Coverage or Covered Services, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts

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

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

Your coverage under this Agreement will terminate if You:

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

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

- **Change the Marketplace Health Plans**: You decide to change from Molina Healthcare to another health plan offered through the Marketplace either:
    - (i) within the first 10 calendar days from the Effective Date of Your coverage if You are not satisfied with Molina Healthcare, or
    - (ii) during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace's special enrollment procedures, or
    - (iii) when You seek to enroll a new Dependent.

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

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation under the terms of Your coverage with Molina Healthcare. We will send You a notice of termination. Some examples include:

- Making a misrepresentation of a material fact on the enrollment application. Molina will not use a statement on the enrollment application to void, cancel or non-renew Your coverage or reduce Your benefits unless (1) the statement is in a written application signed by the Subscriber and (2) a signed copy of the application is or has been furnished to the Subscriber or the Subscriber's personal representative.
- Misrepresenting eligibility information.
- Presenting an invalid prescription or physician order.
- Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina Healthcare may not terminate Your coverage due to any omissions, misrepresentations or inaccuracies in Your application form (whether willful or not).

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

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

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

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

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

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

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

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

  - A statement that Molina Healthcare has not received full Premium payment. We will terminate this Agreement for nonpayment if we do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
  - The amount of Premiums due.
  - The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if we do not receive the required Premiums.

- Except for Subscribers who receive advance payment of the premium tax credit, if You have received a Late Notice that Your coverage is being cancelled or not renewed due to failure to pay Your Premium, Molina Healthcare will give You a 30-day "grace period." Subscribers who receive advance payment of the premium

tax credit will be given a three month "grace period." During the grace period, You can avoid cancellation or nonrenewal by paying the Premium You owe to Molina Healthcare. If You do not pay the Premium by the end of the grace period, this Agreement will be cancelled at the end of the grace period. You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period.

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

Reinstatement after Termination for Nonpayment of Premiums

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

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

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

If You claim that we ended the Member's right to receive Covered Services because of the Member's health status or requirements for health care services, You may request a review or appeal our decision. See the section of this EOC titled "Complaints and Appeals".

YOUR RIGHTS AND RESPONSIBILITIES

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

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

Your Rights
You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare.
- Get information about Molina Healthcare, our providers, our doctors, our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina Healthcare's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).
- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where

legally allowed.*

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

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1 (888) 560-2025.
- Give information to Your doctor, provider, or Molina Healthcare that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed on with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare know about any fraud or wrong doing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active In Your Healthcare
Plan Ahead

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

Make the Most of Doctor Visits

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

Visiting Your Doctor When You are Sick

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

If You would like more information, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025. We are here Monday through Friday, between 8:00 a.m. and 6:00 p.m. CT.

MOLINA HEALTHCARE SERVICES

Molina Healthcare is Always Improving Services

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

If You would like to learn more about what we are doing to improve, please call Molina Healthcare toll-free at 1 (888) 560-2025 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 EOC.

New Technology

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

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

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

What Do I Have to Pay For?

Please refer to the "Molina Healthcare of Texas, Inc. Summary of Benefits" at the front of this EOC for Your Cost Sharing responsibilities for Covered Services.

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

- You ask for and get medical services that are not covered, such as cosmetic surgery.
- You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare. The exception is in the

case of Emergency or out of area Urgent Care Services.

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

Benefits for services provided to Your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as the managing or possessory conservator of the child; and
- Molina Healthcare has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to Molina Healthcare, with a claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator. Molina may deduct from its benefit payments any amounts it is owed by the recipient of the payment. Payment to Your or Your provider, or deduction by Molina Healthcare from benefit payments of amounts owed to Molina Healthcare, will be considered in satisfaction of its obligations to You under the plan. You will receive an explanation of benefits so that You will know what has been paid.

All benefits paid under this EOC on behalf of a covered Dependent child for which benefits for financial and medical assistance are being provided by the Texas Health and Human Services Commission shall be paid to said department when the parent who purchased the individual policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. Molina Healthcare must receive at its Texas office, written notice affixed to the claim when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to the Texas Health and Human Services Commission.

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

While most claims for payment of Covered Services will be submitted directly by Your Participating Providers, You may incur charges for Covered Services can be submitted by You as a claim to Molina Healthcare. For example, you may have received Emergency Services or Urgent Care Services from a no-Participating Provider. With the exception of any required Cost Sharing amounts (such as a Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back. You will need to mail or fax us a copy of the bill from the doctor, hospital or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on the first page of this EOC.

You must provide us with notice of a claim within 20 days following the date of service, unless it is not reasonably possible to do so. Failure to give notice within this time will not invalidate or reduce any claim if You show that it was not reasonably possible to give the notice, and that the notice was given as soon as it was reasonably possible. Within 15 days following our receipt of the notice of claim, we will acknowledge the receipt of the claim, begin our investigation of the claim and request any additional items, statements and forms that we reasonably believe will be required from You. All claims must be properly submitted within 90 days of the date that You receive the services or supplies. Claims not submitted and received by Molina Healthcare within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

After we receive Your claim, we will notify You in writing of the acceptance or rejection of the claim within 15 business days after we receive all the information we need to process the claim. If we need additional time we will notify You of the reasons we need more time, and will accept or reject the claim within 45 days. If Your claim is accepted, we will mail You a check within 5 business days after we have notified You. If You do not agree with our decision, You may appeal our decision as explained under the Complaints and Appeals section of this EOC.

How Does Molina Healthcare Pay for My Care?

Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina Healthcare does not provide financial incentives for utilization management decisions that could result in Referral denials or under-utilization. For more information about how providers are paid, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 560-2025. We are here Monday through Friday, 8:00 a.m. to 6:00 p.m. CT. You may also call Your provider's office or Your provider's medical group for this information.

Interpreter Services
Do You speak a language other than English?

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

Molina Healthcare offers telephone interpreter services to help You with:

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

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina Healthcare sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina Healthcare's Customer Support Center at 1 (888) 560-2025.

Cultural and Linguistic Services
Molina Healthcare can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina Healthcare's Customer Support Center at 1 (866) 560-2025.

COMPLAINTS AND APPEALS

What if I Have a Complaint?

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

- Call Molina Healthcare toll-free at 1 (888) 560-2025. We are here Monday through Friday, 8:00 a.m. - 6:00 p.m. CDT. Deaf or hard of hearing Members may call our toll-free TTY number at 1 (800) 735-2989. You may also contact us by calling the National Relay Service at 711.

- You may also send us Your problem or complaint in writing by mail or filing online at our website. Our address is:

  Molina Healthcare of Texas
  Attn: Member Complaints & Appeals
  6999 McPherson, Suite 212
  Laredo, TX 78041

Molina Healthcare recognizes the fact that Members may not always be satisfied with the care and services provided by our contracted doctors, hospitals and other providers. We want to know about Your problems and complaints. You may file a grievance (also called a complaint) in person, in writing, or by telephone as described above. Molina Healthcare also will provide oral language services that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language. You can request that any notice from Molina Healthcare be provided in any applicable non-English language. With respect to any Texas county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate **only** in the same non-English language as determined by the Department of Health and Human Services (HHS).

Complaints -We will send You a letter acknowledging receipt of Your grievance within 72 hours of receipt of the complaint. Grievances will be resolved within thirty (30) calendar days from receipt of the complaint. A complaint or grievance concerning disagreement or dissatisfaction with an Adverse Benefit Determination constitutes an appeal of that Adverse Benefit Determination. Appeals of Adverse Benefit Determinations will be resolved as noted below.

Appealing Resolution of Complaints – If You are not satisfied with the resolution of Your complaint, You may appeal that resolution in writing. You may request to appear in person before a complaint appeal panel or address a written appeal to the complaint appeal panel. If You appeal the resolution of a Complaint, We will send an acknowledgment letter to You not later than the fifth business day after We receive Your written request for appeal. We will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

If you appeal Your complaint resolution, We will appoint members to a complaint appeal panel to advise the us on the resolution of a disputed decision appealed. The complaint appeal panel will be composed of an equal number of Molina staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision. The physicians or other providers on a complaint appeal panel will have experience in the area of care that is in dispute and must be independent of any physician or provider who made any previous determination. If specialty care is in dispute, the complaint appeal panel will include a person who is a specialist in the field of care to which the appeal relates. The enrollee members of a complaint appeal panel will not be employees of Molina.

Adverse Benefit Determinations

An **"Adverse Benefit Determination"** means a determination by Molina Healthcare that health care services provided or proposed to be provided to a Member are not Medically Necessary or are Experimental or Investigational. If an ongoing course of treatment had been approved by Molina Healthcare and Molina Healthcare reduces or terminates such treatment (other than by amendment or termination of the plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non—payment of premium.

Molina shall provide notice of an adverse determination as follows:

(1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;

(2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or

(3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying poststabilization care subsequent to emergency treatment as

requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

The notice of an adverse determination will include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and

(4) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review.

If the denial involves a life-threatening condition, the notice will also include a description of Your right to an immediate review by an independent review organization and of the procedures to obtain that review.

You may request an Appeal of an Adverse Benefit Determination

Appeal Procedures for Adverse Benefit Determinations (Including Expedited Clinical Appeals)

Expedited Clinical Appeals

If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, Prior Authorization for treatment, denial of emergency care or concurrent or continued hospitalization. Before authorization of benefits for an ongoing course of treatment or concurrent or continued hospitalization is terminated or reduced, Molina Healthcare will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process. The procedure will include a review by a health care provider who has not previously reviewed the case and is of the same specialty or a similar specialty as the health care provider who would typically manage the condition under appeal.

Upon receipt of an expedited Prior Authorization or concurrent clinical appeal, Molina Healthcare will notify the party filing the appeal as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. Molina Healthcare will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by Molina Healthcare.

How to Appeal an Adverse Benefit Determination

An appeal of an Adverse Benefit Determination may be filed by You or a person authorized to act on Your behalf, or Your health care provider. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call Molina Healthcare at 1 (888) 560-2025. Molina Healthcare will review its decision in accordance with the following procedure:

- Within 180 days after You receive notice of an Adverse Benefit Determination, You may call or write to Molina Healthcare to request an appeal. We will need to know the reasons why You do not agree with the Adverse Benefit Determination. Send Your request to:

For review of claims for payment or reimbursement:

Molina Healthcare of Texas, Inc.
15115 Park Row, Suite 160
Houston, TX 77084

For appeal of requests for services, including Prior Authorization:

Molina Healthcare of Texas, Inc.
6999 McPherson Ave, Suite 212
Laredo, TX 78041
Attn: Healthcare Services Appeals

We also will take telephone requests for an appeal. Within 5 working days from the date we receive Your appeal, we will send You a letter acknowledging the date of receipt, the procedures to be followed in the appeal and a list of documents that You must submit for review. When we receive an oral appeal, we will send You a short appeal form. In support of Your appeal, You have the option of presenting evidence and testimony to us. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the appeal process. A physician will make the appeal decision.

Molina Healthcare will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of Your appeal without regard to whether such information was considered in the initial determination.

We will not rely on the initial Adverse Benefit Determination. Any new or additional evidence or rationale will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a physician associated or contracted with Molina Healthcare and/or by external advisors, but who were not involved in making the initial denial of Your claim. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal , and the appeal must be finally decided by Molina Healthcare.

If you have any questions about the appeals procedures, write to us at the above address or call us at 1 (888) 560-202. This appeal process does not prohibit you from pursuing civil action available under the law.

Timing of Appeal Determinations

Molina Healthcare will make a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by us.

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Notice of Appeal Determination

Molina Healthcare will notify the party filing the appeal, You, and, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:

- The clinical basis for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
- The specialty of the physician or other health care provider making the determination;

- In certain situations, a statement in non—English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non—English language(s) and how to access Molina Healthcare's language services;If the decision is a denial, the specialty of the physician or other health care provider making the denial; and
- An explanation of Molina Healthcare's external review process to an Independent Review Organization (and how to initiate an external review of the determination).

Your external review rights are described below in the ***Appeal to an Independent Review Organization (IRO)*** section below.

APPEAL TO AN INDEPENDENT REVIEW ORGANIZATION (IRO)

You may request an appeal to an Independent Review Organization ("**IRO**") of a denial of an appeal of an Adverse Benefit Determination made by Molina Healthcare.

This procedure is not part of the complaint process and pertains only to appeals of Adverse Benefit Determinations. In addition, in life-threatening or urgent care circumstances, You are entitled to an immediate appeal to an IRO and are not required to comply with Molina Healthcare's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by Molina Healthcare may seek review of the decision by an IRO. At the time the appeal is denied, we will provide You, Your designated representative or Provider of record, information on how to appeal the denial, including any approved form, which You, Your designated representative, or Your provider of record must complete. In life-threatening or urgent care situations, You, Your designated representative, or Your provider of record may contact Molina Healthcare by telephone to request the review and provide the required information. For all other situations, You or Your designated representative must request the IRO review in writing to Molina Healthcare to begin the independent review process.

- Molina Healthcare will submit medical records, names of providers and any documentation pertinent to the decision of the IRO within 3 business days of receiving Your request for an IRO review.
- Molina Healthcare will comply with the decision by the IRO.
- Molina Healthcare will pay for the independent review.

Upon request and free of charge, You or Your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by Molina Healthcare;
- medical judgments, including whether a particular service is Experimental or Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by Molina Healthcare in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit You from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places your health in serious jeopardy.

For more information about the IRO process, call Texas Department of Insurance (TDI) on the IRO information line at (888) TDI-2IRO (834-2476), or in Austin call (512) 322-3400.

VOLUNTARY ARBITRATION:

VOLUNTARY OPTION TO RESOLVE ALL DISPUTES BY BINDING ARBITRATION. MEMBERS PURSUING PERSONAL INJURY AND MEDICAL MALPRACTICE CLAIMS MUST FILE SUCH CLAIMS IN A COURT OF LAW.

* *Important Information About Your Rights* *

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product, which may include but are not limited to claims of malpractice (e.g., in the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the healthcare provider) or claims that the medical services rendered under the product were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, between Member (including any heirs, successors or assigns of the Member) and Molina Healthcare, or any of its parents, subsidiaries, affiliates, successors or assigns may be submitted to binding arbitration in accordance with applicable state and federal laws including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, the Affordable Care Act, and the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code, Ch. 171, Section 171.001 *et seq.*) Any such dispute submitted to binding arbitration will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

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

- The final and binding arbitration shall be conducted in accordance with the Comprehensive Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

- The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days from the date the notice of commencement of the arbitration is received, the

arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

- Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the Texas General Arbitration Act (Tex. Civ. Prac. & Rem. Code, Ch. 171, Section 171.001 *et seq.*). The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Texas state law court, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

  The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. Proceeding with binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.
- The parties shall divide equally the costs and expenses of JAMS and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The hardship application shall be made in a manner and with the information and any documentation as required by JAMS. JAMS (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

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

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

OTHER

MISCELLANEOUS PROVISIONS

Acts Beyond Molina Healthcare's Control

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

Waiver

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

Non-Discrimination

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

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 560-2025.

Organ or Tissue Donation

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 making that selection when you renew your Driver's License or pick up a form at your nearest Department of Public Safety office, or you can go online at www.donatelifeTexas.org to register.

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 Texas 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 not in conformity with applicable laws in a judicial proceeding or binding arbitration, such provision shall not be considered to be invalid but shall be construed and applied as if it were in full compliance with the Insurance Code Chapter 1271 and other applicable laws, and the remainder of this Agreement shall remain operative and in full force and effect.

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

HEALTH EDUCATION SERVICES

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

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

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

We also offer programs to help You manage Your current health conditions. These include weight management and smoking cessation. If You want to learn about these programs, a Molina Care Manager may contact You. You can also enroll in any of these programs by calling the Molina Healthcare Health Education Department at 1866-472-9483. We are here between 8:00 a.m. and 6:00 p.m., Monday through Friday.

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

Call toll-free 1 866-472-9483 (Monday through Friday, 8:00 a.m. – 6:00 p.m.).

Motherhood Matters℠

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

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

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

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

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

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

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. Specialized services are available for teens, pregnant smokers and tobacco chewers. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support. You will also be given a telephone number that You can call anytime You need help.

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

The weight control program is provided for Members 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program and attend classes. Call the Health Education Department at 1-866-472-9483 to find the program location that is closest to Your area.

Health Education Materials
Molina Healthcare offers a variety of easy-to-read educational materials. Many are available in different languages. Some of the topics are on nutrition, stress management, child safety, asthma, and diabetes. You can get any of these materials by calling the Health Education Department at 1-866-472-9483.

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Molina Healthcare of Texas, Inc. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Molina Healthcare at 1-888-560-2065*

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

a. 48 hours following a mastectomy; and
b. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:
(a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
(b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
(c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
(d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Coinsurance and copayment amounts will be the same as those applied to other similarly covered Inpatient Hospital Expense or Medical-Surgical Expense, as shown on the Schedule of Coverage.

Prohibitions: We may not:
(a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
(b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or
(c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Examinations for the Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

a. A physical examination for the detection of prostate cancer; and
b. A prostate-specific antigen test for each covered male who is:
   (1) At least 50 years of age; or
   (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; and
b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. Give birth in a hospital or other health care facility; or
b. Remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast—feeding and bottle—feeding and the performance of any necessary and appropriate clinical tests. Care is provided by a physician, registered nurse or other appropriately licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions: We may not:

(a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;

(b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;

(c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;

(d) reduce payments or reimbursements below the usual and customary rate; or

(e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

For each woman enrolled in the plan who is 18 years of age or older, expenses are covered for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid—based cytology methods. The method must be approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

Your health benefit plan coverage for an acquired brain injury includes the following services:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

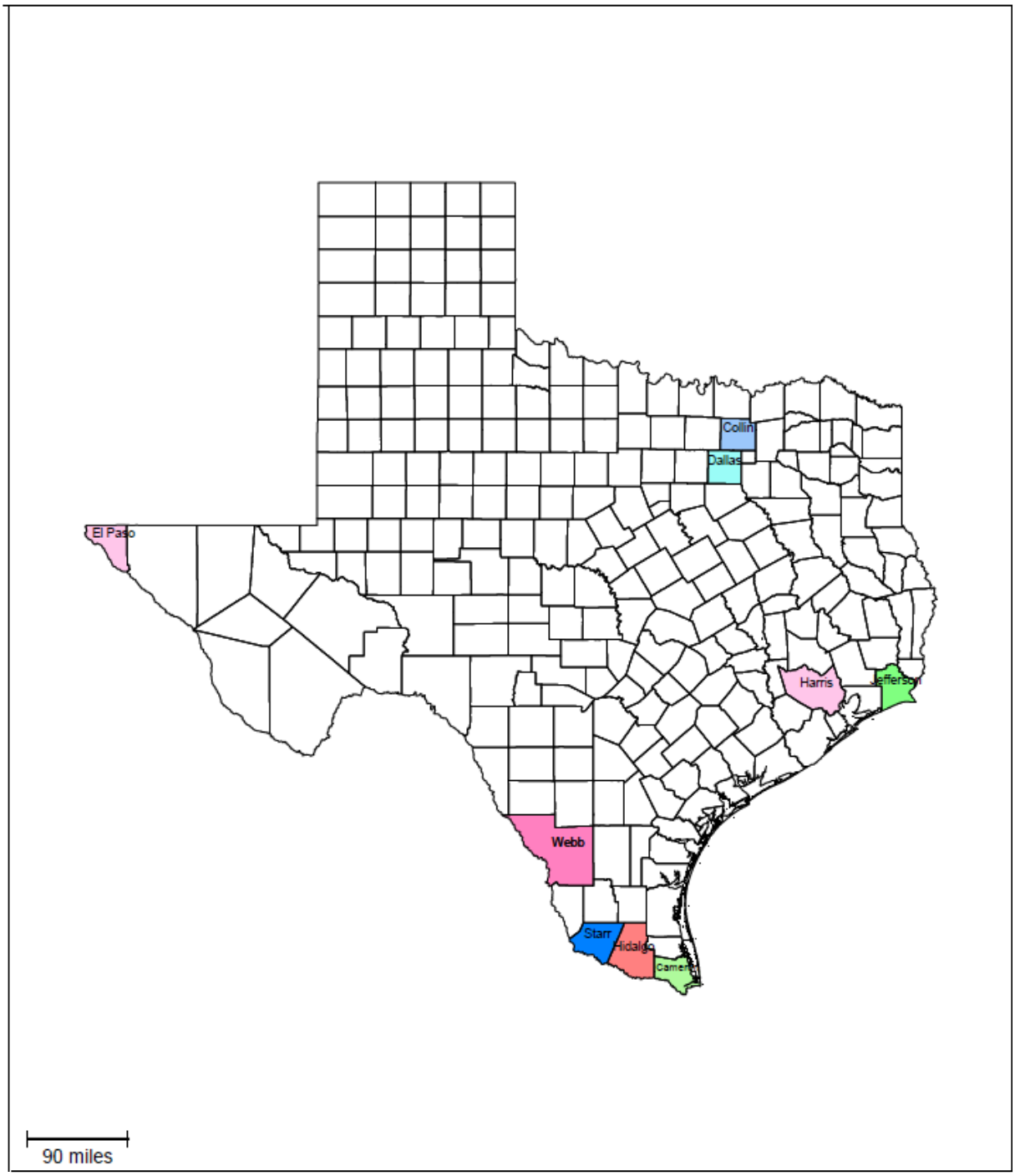
The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the Member or Subscriber to receive the preceding treatments or services commensurate with their condition. Post-acute treatment or services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

Your Healthcare 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 8:00am to 6:00pm. When in doubt, call us first.	**Customer Support Center Toll Free:** 1 (888) 560-2025 **TTY line for the deaf or hard of hearing:** 1 (800) 735-2989 or dial 711 for the National Relay Service
Health Education	To request any information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes.	1 (866) 472-9483
Nurse Advice Line 24-Hour, seven days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750
Motherhood Matters	Molina Healthcare offers a special program called Motherhood Matters to our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that we have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE **TTY for deaf or hard of hearing:** 1 (877) 486-2048 **www.Medicare.gov**
Texas Department of Insurance	The Texas Department of Insurance is responsible for regulating health care services plans. If You have a grievance against Your health plan, You should first call Molina Healthcare toll-free at 1-888-560-2025, and use Molina Healthcare's grievance process before contacting this department.	**1-800-252-3439** Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.state.tx.us

Molina Healthare of Texas, Inc. Service Area Map

Cameron, Collin, Dallas, El Paso, Harris, Hidalgo, Jefferson, Starr and Webb Counties.



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