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

Molina Marketplace Gold Plan

7050 Union Park Center
Suite 200
Midvale, Utah 84047

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.

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Subscriber may cancel and return this Agreement and Individual Evidence of Coverage to Molina Healthcare of Utah, Inc. within 10 calendar days after delivery and receive a premium refund. If Covered services are received by any Member during this 10 day examination period, then the Subscriber must pay the full cost of those Covered Services if his or her premium has been returned.

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

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

This EOC will renew on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Further information regarding renewal, non-renewal and termination may be found on page 66 of this EOC.

WELCOME

Welcome to Molina!

Here at Molina, 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 Utah licensed Health Maintenance Organization.

If You are thinking about becoming a Molina Member, this EOC can help You make a decision. You may call Molina and request information about Molina's health plans and disclosure information. 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 Utah, Inc.
Customer Support Center
7050 Union Park Center, Suite 200
Midvale, UT 84047
1 (888) 858-3973
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) 346-4128 or by dialing 711 for the National Relay Service.

MOLINA HEALTHCARE OF UTAH, INC.
BENEFITS AND COVERAGE GUIDE

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

NOTICE: THIS PRODUCT DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT. COVERAGE FOR PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE ON A STANDALONE BASIS THROUGH THE HEALTH INSURANCE MARKEPLACE. PLEASE CONTACT THE HEALTH INSURANCE MARKETPLACE IF YOU WISH TO PURCHASE PEDIATRIC DENTAL SERVICES.

Deductible Type	**You Pay**
Medical Deductible(Applies only to outpatient Hospital/facility and inpatient Hospital/facility services, Cost Share applies if applicable)	
Individual	$500
Entire Family of 2 or more	$1,000
Other Deductibles	
Prescription Drug Deductible	
Individual	$0
Entire family of 2 or more	$0

Annual Out of Pocket Maximum	**You Pay**
Individual	$6,600
Entire Family of 2 or more	$13,200

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

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

Outpatient Professional Services		**You Pay**
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care	$15	Copayment per visit

Specialty Care	$35	Copayment per visit
Other Practitioner Care	$35	Copayment per visit
Habilitative Services (the Habilitative Services and Rehabilitative Services benefits have a combined limit of 20 visits per calendar year)	20%	Coinsurance
Rehabilitative Services (the Rehabilitative and Habilitative Services benefits have a combined limit of 20 visits per calendar)	20%	Coinsurance
Mental Health Services	$15	Copayment per visit
Substance Abuse Services	$15	Copayment per visit
Phenylketonuria (PKU)		
Preventive Care Screening for Children	No Charge	
Testing and Treatment of PKU	$15	Copayment
Family Planning	No Charge	
Pediatric Vision Services (for Members under Age 19 only)		
Office visit/exam (one per calendar year)	No Charge	
Corrective lenses (one set of corrective lenses once every 12 months	No Charge	

Outpatient Hospital / Facility Services		**You Pay**
Outpatient Surgery and Other Procedures		
Professional	20%	Coinsurance after deductible
Facility	20%	Coinsurance after deductible
Chemotherapy Services	20%	Coinsurance after deductible
Radiation Services	20%	Coinsurance after deductible
Specialized Scanning Services		
CT Scan	20%	Coinsurance after deductible
PET Scan	20%	Coinsurance after deductible
MRI	20%	Coinsurance after deductible
Radiology Services	$35	Copayment
Laboratory Services	$15	Copayment
Mental Health		
Outpatient Intensive Psychiatric Treatment Programs	20%	Coinsurance after deductible
Inpatient Hospital Services		**You Pay**
Medical / Surgical		
Professional	20%	Coinsurance after deductible

Facility	20%	Coinsurance after deductible
Maternity Care (professional and facility services)	20%	Coinsurance after deductible
Mental Health (Inpatient Psychiatric Hospitalization)	20%	Coinsurance after deductible
Substance Abuse		
Inpatient Detoxification	20%	Coinsurance after deductible
Transitional Residential Recovery Services	20%	Coinsurance after deductible
Transplant Services	20%	Coinsurance after deductible
Skilled Nursing Facility (30 days per calendar year)	20%	Coinsurance after deductible
Hospice Care (limited to 6 months in a 3 year period)	No Charge	

Prescription Drug Coverage*		**You Pay**
Tier 1 - Formulary Generic Drugs	$15	Copayment
Tier 2 - Formulary Preferred Brand Name Drugs	$35	Copayment
Tier 3 - Formulary Non-Preferred Brand Name Drugs	20%	Coinsurance
Tier 4 - Specialty Drugs (Oral and Injectable Drugs)	20%	Coinsurance

***Please refer to Page 48 for a description of Prescription Drug Benefits.**

Ancillary Services		**You Pay**
Durable Medical Equipment	20%	Coinsurance
Home Healthcare (30 visits per calendar year)	$35	Copayment per visit
Emergency Medical Transportation (Ambulance)	$250	Copayment
Non-Emergency Medical Transportation (Combined Non-Emergency Medical and Non-Emergency Non-Medical Transportation limit of 4 round trips per month)	Not Covered	
Non-Emergency Non-Medical Transportation (Combined Non-Emergency Medical and Non-Emergency Non-Medical Transportation limit of 4 round trips per month)	Not Covered	

Other Services		**You Pay**
Dialysis Services	$35	Copayment

Other Services		**We Pay**
Adoption Indemnity Benefit	$4,000	Per Adoption*

*** If more than one child from the same birth is placed for adoption with the Subscriber, only one adoption indemnity benefit will be paid. Please refer to Page 56 for a description of Adoption Benefits and restrictions.**

INTRODUCTION

THANK YOU FOR CHOOSING MOLINA HEALTHCARE AS YOUR HEALTH PLAN.

This document is called Your "Molina Healthcare of Utah, Inc. Agreement and Individual 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 and keep it in a safe place where You can get to it quickly. If You have special health care needs, carefully read the sections that apply to You.

MOLINA HEALTHCARE IS HERE TO SERVE YOU.

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

Call us toll-free at 1 (888) 858-3973 between 9:00 a.m. to 5:00 p.m. MT 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) 346-4128 or by dialing 711 for the National Relay Service.

Call us if You move from the address You had when You enrolled with Molina Healthcare. Let us know if you change phone numbers. Please contact Our Customer Support Center to update that information.

Sharing Your updated address and phone number with Molina Healthcare this will help us get information to You. We can send You newsletters and other materials. We can reach You by phone if We need to contact You.

YOUR PRIVACY

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

Your Protected Health Information

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

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

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

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

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

What are Your privacy rights?

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

How does Molina Healthcare protect Your PHI?

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

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

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. **Our Notice of Privacy Practices is in the following section of this EOC and is on Our web site at www.molinahealthcare.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center at 1-888-858-3973.**

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF UTAH, 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 Utah, 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, 2015.

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

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

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

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

For Health Care Operations
Molina Healthcare may use or share 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 or rules;
- Address Member needs,

- Solving complaints and grievances.

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

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

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

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

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

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

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

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

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

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

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

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

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the

following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave to us.

What are Your health information rights?
You have the right to:

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

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

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

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

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

  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with Your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - 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 1-888-858-3973.

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
7050 Union Park Center, Suite 200
Midvale, UT 84047
1-888-858-3973

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
999 18th Street, Suite 417
Denver, CO 80202
1 (800) 368-1019; 1 (800) 537-7697 (TDD)
1 (303) 844-2025 (FAX)

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

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

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

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

Customer Support Center
7050 Union Park Center, Suite 200
Midvale, UT 84047
Phone: 1 (888)-858-3973

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**"

- **For Individuals** - is the total amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. For this EOC, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the individual Annual Out-of-Pocket Maximum.

- **For Family (2 or more Members)** – is the total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. For this Agreement, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the family Annual Out-of-Pocket Maximum.

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

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

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

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

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

"Deductible" is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. Please refer to the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

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

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

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

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in 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 acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain); such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Placing the health of the Member, or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

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

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

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

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

"**Experimental or Investigational**" means medical treatments, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the FDA, the American Medical Association, or the Surgeon General.

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

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

A Hospital is a legally operated facility licensed by the state, operating within the scope of its license.

"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 Utah 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 Utah, 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. Those services must be deemed by Molina to be:

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

"**Molina Healthcare of Utah, Inc. Agreement and Individual 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, which 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 Specialist Physician 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

- A Primary Care Doctor, or
- 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 Utah where Molina has been authorized by the Utah Insurance Department 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.

"**Subscriber**" means an individual who is a resident of Utah, 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. In the event of the death of the Subscriber, a dependent Spouse covered under this EOC shall become the Subscriber.

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

For coverage during the calendar year 2015, the initial open enrollment period begins November 15, 2014 and ends February 15, 2015. Your Effective Date for coverage during 2015 will depend on when You applied:

- If You applied on or before December 15, 2014, the Effective Date of Your coverage is January 1, 2015.
- If You applied between December 16, 2014 and January 15, 2015, the Effective Date of Your coverage is February 1, 2015.

- If you applied from January 16, 2015 through February 15, 2015, the Effective Date of Your coverage is March 1, 2015.

If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period for which You are determined eligible under special enrollment procedures established by the Marketplace and/or Molina Healthcare. In such case, the Effective Date of coverage will be as determined by the Marketplace. Without limiting the above, the Marketplace and Molina Healthcare will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

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

WHO IS ELIGIBLE?

To enroll and continue enrollment, You must meet all of the eligibility requirements established by the Marketplace. Check the Marketplace's website for eligibility criteria. Molina Healthcare requires You to live or work in Molina Healthcare's Service Area for this product. If You have lost Your eligibility, as described in the section titled "When Will My Molina Healthcare Membership End? (Termination of Benefits and Coverage)", You may not be permitted to re-enroll.

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

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age). Dependent children living outside of Molina's Service Area are also eligible to apply for enrollment until the age of 26 (the limiting age). Except as otherwise noted below with respect to Dependent Children enrolled pursuant to a court or administrative order, the Dependent child's coverage is subject to the terms and conditions of this Agreement, irrespective of whether the child lives inside or outside of Molina's Service Area. For example, for a Dependent child's health care to be covered under this product, the health care services must be received from Molina Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of Emergency Services or out of area Urgent Care Services.
- Subscriber's grandchildren do not qualify as Dependents of the Subscriber.

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

- Share a permanent residence with the Subscriber;
- Have resided with the Subscriber for not less than one year (365 days);
- Be at least 18 years of age;

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

PLEASE NOTE:

A person is not eligible to enroll as a domestic partner if either such person or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve (12) months prior to designating each other as domestic partners under this product; are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex. An eligible domestic partner's natural or adopted children who meet the Dependent eligibility requirements for enrollment in this product are also eligible to enroll as Dependent children.

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

- The child is incapable of self-sustaining employment 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 or the Marketplace 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 or the Marketplace with proof of his or her child's incapacity and dependency within 30 days of the date of receiving such notice in order to continue coverage for a disabled child past the limiting age.

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

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

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

- **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, birth, or adoption;
  - The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
  - A court or administrative order is entered which requires the Subscriber or Spouse to provide health coverage for their child. However, if the Subscriber or Spouse fails to enroll the child, the child's other parent or appropriate governmental agency may enroll the child. A copy of the written court or administrative order requiring the Subscriber or Spouse to enroll the child will be required. Note that Molina will pay for otherwise Covered Services rendered to the child outside of the Service Area by a non-Participating Provider if the child, noncustodial parent, or custodial parent has complied with Prior Authorization or utilization review otherwise required by this EOC. We will pay to the non-Participating Provider, custodial parent, Dependent child who obtained Covered Services, or Utah Medicaid agency the amount that We pay to similar Participating Providers for comparable Covered Services. The parents of the Dependent child enrolled pursuant to a court or administrative support order are responsible for any charges billed by the non-Participating Provider in excess of those paid by Molina Healthcare.

- **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 to control the child's health care, whichever is earlier, unless the adoption placement occurs within 30 days of the child's birth in which case coverage will be from the moment of birth. 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 Care Facility minor release report, a medical authorization form, or a relinquishment form) or other evidence that shows You or Your Spouse have the legal right to control the child's health care. Coverage is not subject to any preexisting conditions and includes any injury or sickness, including the necessary care and treatment of medically diagnosed: congenital defects; birth abnormalities; or prematurity.

A claim for services for a newly born child or an adopted child may be denied until the child is enrolled. The claim may be resubmitted for reprocessing once a child meets eligible criteria.

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 last day of the month in which 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. Coverage for newborn children of a covered Dependent child will end when the covered Dependent child is no longer eligible under this Agreement.
- The date the Dependent Spouse enters a final decree of divorce, annulment, or dissolution of marriage. Upon the entry of the divorce decree the spouse is entitled to have issued an individual policy without evidence of insurability, upon application to Molina and payment of the appropriate premium.
- The date the Dependent domestic partner enters a termination of the domestic partnership from the Subscriber. Upon the entry of the termination of the domestic partnership, the former Dependent domestic partner is entitled to have issued an individual policy without evidence of insurability, upon application to Molina and payment of the appropriate premium.

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

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

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

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

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

MEMBER IDENTIFICATION CARD

HOW DO I KNOW IF I AM A MOLINA HEALTHCARE MEMBER?

You get a Member identification (ID) card from Molina Healthcare. Your ID card comes in the mail. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call Molina Healthcare toll-free at 1 (888) 858-3973. We will be happy to send You a new ID card.

If You have questions about a how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3973.

WHAT DO I DO FIRST?

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

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

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

ACCESSING CARE

HOW DO I GET MEDICAL SERVICES THROUGH MOLINA HEALTHCARE?

(Choice of Doctors and Providers; Facilities)

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

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

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

If You need Hospital or similar services, You must go to a Health Care 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) 858-3973. 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. WHOM TO CALL.
Emergency Services	Call 911 or go to the nearest emergency room. Even when outside Molina's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	Call Your PCP or Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or for directions; for Spanish, call 1 (866) 648-3537 for directions. For out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • 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.
For mental health or substance abuse evaluation	Go to a qualified mental health Participating Provider. You do not need a Referral or Prior Authorization to get a mental health or substance abuse evaluation.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHOM TO CALL.
For mental health or substance abuse therapy	For mental health or substance abuse therapy, a Referral from your qualified mental health Participating Provider is needed.
To see a Specialist Physicians (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 Services 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.
To go to the Hospital	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.
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, 1 (866) 648-3537.

WHAT IS A PRIMARY CARE PROVIDER (PRIMARY CARE PHYSICIANS, PRIMARY CARE DOCTOR OR PCP)?

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) 858-3973.

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 30 for more information about the coverage of Emergency Services and out of area Urgent Services.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and Hospitals that are available under Molina Healthcare's health plan. You will also learn some helpful tips on how to use Molina Healthcare's services and benefits. Your Provider Directory was included in the materials You received from Molina Healthcare. If You did not get a Provider Directory, then please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3973.

You can find the following in Your Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors, and Specialists Physicians.

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: 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) 858-3973 to make sure that You can get the health care services that You need.

HOW DO I CHOOSE A PRIMARY CARE PROVIDER (PCP)?

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

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

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina Healthcare toll-free at 1 (888) 858-3973. 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) 858-3973, Monday through Friday, 9:00 a.m. to 5:00 p.m. MT You may also visit Molina Healthcare's website at www.molinahealthcare.com to view Our online list of doctors. Let us help You make the change.

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

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

WHAT IF MY DOCTOR OR HOSPITAL IS NO LONGER WITH MOLINA HEALTHCARE?

If Your doctor (PCP or Specialist Physicians) or a Hospital is no longer with Molina Healthcare, We will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. Our Molina Healthcare Customer Support Center staff can help You make a choice.

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

In the event that Molina Healthcare is subject to a finding of insolvency, the rehabilitator or liquidator may require a Participating Provider to continue to provide services to You until the earlier of 90 days after the date of filing of a petition of rehabilitation or a petition for liquidation, or the date on which the contract between Molina Healthcare and the Participating Provider ends.

If You want to request that You stay with the same doctor or hospital for continuity of care, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3937. If You are deaf or

hard of hearing, call our dedicated TTY line toll-free at 1 (800) 346-4128. You may also dial 711 for the National Relay Service.

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. If You are deaf or hard of hearing access Nurse Advice with the National Relay Service by dialing 711. The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

WHAT IS A PRIOR AUTHORIZATION?

A **Prior Authorization** is a request for You to receive a Covered Service from Your doctor. Molina Healthcare 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)
- Certain prescription and Specialty Drugs, excluding contraception
- Cochlear implants
- Continuous glucose monitoring devices and supplies
- 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 $750
- Endovenous abalation therapy (radiofrequency or laser)
- 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
- Genetic Testing for high risk pregnancies (Medically Necessary)
- Habilitative services
- Home health care

- Hospice inpatient care – notification only
- Imaging (special testing such as CT (computed tomography), MRI (magnetic resonance imaging), MRA (magnetic resonance angiogram), cardiac scan and PET (positron emission tomography) scan)
- Implantable medications
- Implantation of artificial devices
- Intrathecal pumps
- Jaw surgery
- Magnetoenecephalography (MEG)/magnetic source imaging
- Mental health services
- Office based podiatry (foot) surgery
- Outpatient Hospital / ambulatory surgery center procedures subject to exceptions*****
- Pain management services and procedures
- Pregnancy and delivery – notification only
- Rehabilitative services
- Specialty pharmacy
- Stereotactic radiosurgery
- Substance abuse services
- Transanal endoscopic microsurgery
- 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) 858-3973 if You need to determine if Your service needs Prior Authorization.

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

Approvals are given based on Medical Necessity. If You have questions about how a certain service is approved, call Molina Healthcare toll-free at 1 (888) 858-3973. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4128 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. Routine Prior Authorization requests will be processed within five business days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination, and no longer than 14 calendar days from the receipt of the request. Medical conditions that may cause a serious threat to Your health are processed within 72 hours from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina Healthcare processes requests for urgent specialty services immediately by telephone.

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

decision. The denial letter will tell You how to appeal. These instructions are also noted on page 79 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 Physicians, You will not need to get a Referral or Prior Authorization every time You see that Specialist Physicians. Also, if Your condition or disease is life threatening, worsening, or disabling, You may need to receive a standing approval to a Specialist Physicians 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) 858-3973 or call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 346-4128 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 79.

Second Opinions
You or Your PCP may want another doctor (a PCP or a Specialist Physicians) 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 SERVICES AND URGENT CARE SERVICES

WHAT IS AN EMERGENCY?
Emergency Services mean health care services needed to evaluate, stabilize or treat an **Emergency Medical Condition.** 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 health in serious danger.**
- **Serious damage to bodily functions.**
- **Serious dysfunction of any bodily organ or part.**

Emergency Services also includes Emergency contraceptive drug therapy.

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

HOW DO I GET EMERGENCY SERVICES?

Emergency care is available 24 hours a day, 7 days a week for Molina Healthcare Members.

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

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

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

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

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

What if I'm away from Molina's Service Area and I need Emergency Services?
Go to the nearest emergency room for care. Please contact Molina within 24 hours, or when medically reasonable, of getting urgent or Emergency health care. Call toll-free at 1 (888) 858-3973. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4128. 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, call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 for Spanish 1 (866) 648-3537 for directions. Our nurses can help You any time of the day or night. They will tell You what to do or where to go to be seen.

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

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

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 U.C.A. § 31A-22-617 and 45 C.F.R. § 147.138, as applicable. You may be responsible for charges that exceed the allowed amount covered under this benefit.
- Emergency contraceptive drug therapy, whether provided by Participating or Non-Participating Providers, is not subject to Cost Sharing.

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 that 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) 858-3973 or call Our dedicated TTY for the deaf or hard of hearing toll-free at 1 (800) 346-4128 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) 858-3973, Monday through Friday from 9:00 a.m. to 5:00 p.m. MT. 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, 9:00 a.m. to 5:00 p.m. MT.

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) 858-3973 or call Our dedicated TTY line toll-free at 1 (800) 346-4128 and a Customer Support Center Representative will help You find another doctor.

ACCESS FOR THE DEAF OR HARD OF HEARING

Call Molina Healthcare's Customer Support Center through Our TTY Number toll-free at 1 (800) 346-4128, or by using a National Relay Service by dialing 711.

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)
858-3973. 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 Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide 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 Utah, 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 UTAH, INC. BENEFITS AND COVERAGE GUIDE CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

- **For Individuals** – The Annual Out-of-Pocket Maximum is the total amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. For this Agreement, Cost Sharing includes payments You make towards any Deductible, Copayments, and Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the individual Annual Out-of-Pocket Maximum.

- **For Family (2 or more Members)** – The Annual Out-of-Pocket Maximum is the total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. For this Agreement, Cost Sharing

includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the family Annual Out-of-Pocket Maximum.

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 Utah, Inc. Benefits and Coverage Guide. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

Copayment

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

Deductible

Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. Please refer to the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

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

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

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

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 Utah, Inc. Benefits and Coverage Guide 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. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan evidence of coverage. You must also have had 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. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this EOC. However, 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. However, You will not be eligible for pediatric services that are Covered Services under this Agreement if You are 19 years of age or older. This includes pediatric dental separately provided through the Marketplace and vision services.

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, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable

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

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

WHAT IS COVERED UNDER MY PLAN?

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

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

You have the right to appeal if a service is denied. Turn to page 79 for information on how You can have Your case reviewed (see Complaints and Appeals).

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Go to page 62 for information. Molina Healthcare also may cover routine medical costs for Members in Approved Clinical Trials. Go to page 46 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 pages 27 – 28. However, Prior Authorization will never apply to treatment of Emergency Medical 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 You 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 Utah law or rule. 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 You paying any Cost Sharing if furnished by a Participating Provider:

- Complete health history
- Physical exam including growth assessment
- Nutritional health assessment
- Routine vision exam once per year for children between the ages of 3 and 5
- Vision acuity screening for all children
- 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.
- Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Depression screening: adolescents
- Hemoglobinopathies or sickle cell 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
- Alcohol and drug assessment
- Autism screening for children 18-24 months
- Cervical dysplasia screening
- Dyslipidemia screening for children at high risk of lipid disorder
- Hematocrit or hemoglobin screening
- HIV screening
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling
- Fluoride chemoprevention supplements for children without fluoride in their water source

*****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 You 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) – once per year
- 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 and counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing exams and screenings
- Preventive vision screenings
- Abdominal aortic aneurysm screening for men 65 to 75 who have ever smoked
- Alcohol misuse counseling
- Anemia screening for pregnant women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA 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
- Gonorrhea screening
- Syphilis screening
- Tobacco use counseling and interventions
- Well-woman visits

- Screening and counseling for interpersonal and domestic violence: women
- Diabetes screening
- Type 2 Diabetes screening for adults with high blood pressure
- FDA-approved contraceptive methods and counseling, including prescription birth control, supplies , devices and birth control pills

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)
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Physician care in or out of the Hospital
- Consultations and well-child care
- If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) for routine examinations and prenatal care.
- 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 Medically Necessary habilitative health care services. Habilitative services are defined as health care services and devices that are designed to assist individuals acquiring, retaining or improving self-help, socialization, and adaptive skills and functioning necessary for performing routine activities of daily life successfully in their home and community based settings. These services may include physical therapy, occupational therapy, speech therapy, and durable medical equipment. The Habilitative Services and Rehabilitative Services benefits have a combined benefit limit of 20 visits per year.

REHABILITATIVE SERVICES

We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy and occupational therapy in a setting appropriate for the level of disability or injury. The Rehabilitative Services and Habilitative Services benefits have a combined benefit limit of 20 visits per year.

OUTPATIENT MENTAL 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 or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is identified in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The "mental disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We 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

OUTPATIENT SUBSTANCE ABUSE SERVICES

We cover the following outpatient care for treatment of ICD-9 substance abuse diagnosis codes set forth in the Outpatient Mental Health Services benefit:

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

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

PEDIATRIC VISION SERVICES

We cover the following vision services for Members between age five and 18 (i.e., until the Member reaches the age of 19):

- Vision exam – one per year
- Corrective lenses, limited to one set of corrective lenses once every 12 months

Laser corrective surgery is not covered.

FAMILY PLANNING

We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the FDA. 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 management and counseling to help You make informed choices and to understand

birth control methods.

- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use.
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera.
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers including insertion and extraction of IUDs.
- Birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency.
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Pregnancy testing and counseling.
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated.
- Screening, testing and counseling of at-risk individuals for HIV, and Referral for treatment.

PREGNANCY TERMINATIONS

Molina covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by U.C.A. § 31A-22-726.

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

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital setting, Prior Authorization is required.

Office Visit and Outpatient Surgery Cost Sharing will apply.

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

PHENYLKETONURIA (PKU)

We cover testing and treatment of phenylketonuria (PKU), including formulas and special food products that are part of a diet 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.

Outpatient Professional Services Cost Share 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 Health Care Facility services.

OUTPATIENT PROCEDURES (OTHER THAN SURGERY)

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

CHEMOTHERAPY SERVICES

We cover chemotherapy drugs and related services when prescribed and administered by Participating Providers.

RADIATION SERVICES

We cover radiation services and treatment, including radioactive materials used for therapeutic purposes when provided by Participating Providers.

SPECIALIZED SCANNING SERVICES

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

RADIOLOGY SERVICES

We cover x-rays and radiology services, other than specialized scanning services, when furnished by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services.

LABORATORY SERVICES

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. However, epidemiological and predictive genetic screening is not covered, except for intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as required under the Affordable Care Act Preventive Services.

MENTAL HEALTH
OUTPATIENT INTENSIVE PSYCHIATRIC TREATMENT PROGRAMS

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

- Short-term Hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL SERVICES

You must have 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 Physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the Hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Radiation services and treatment, including radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)

- Respiratory therapy
- Medical social services and discharge planning

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 96hours following a delivery by Cesarean section (C-section). Longer stays require Prior Authorization from Molina Healthcare. (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 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. It also covers other Participating Providers who are licensed health care professionals acting within the scope of their license.

We cover inpatient hospital mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The mental disorder must result 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

SUBSTANCE ABUSE
INPATIENT DETOXIFICATION

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

SKILLED NURSING FACILITY

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

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

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

The SNF benefit limit is 30 days per calendar year.

HOSPICE CARE

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

The hospice benefit is for people who are diagnosed with a terminal illness (life expectancy of twelve (12) months or less). They can choose hospice care instead of the traditional services covered by the plan. Please contact Molina Healthcare for further information. You must receive Prior Authorization for all hospice care services. Hospice services are limited to 6 months per 3 year period.

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

All approvals and authorization requirements that apply to routine care for Members not in approved clinical trials 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 Utah, Inc. Benefits and Coverage Guide.

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

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

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

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

reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

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

RECONSTRUCTIVE SURGERY EXCLUSIONS

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

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

TRANSPLANT SERVICES

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

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

- If either the physician or the referral Health Care Facility determines that You do not satisfy its respective criteria for a transplant, Molina Healthcare will only cover services You receive before that determination is made
- Molina Healthcare is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with Our guidelines for services for living transplant donors, Molina Healthcare provides certain donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 858-3973.

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

Molina Healthcare provides or pays for donation-related services for actual or potential donors that 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 and the drug is listed in the Molina

Healthcare Drug Formulary or has been approved by Molina Healthcare's Pharmacy Department

- They are ordered or given while You are in an emergency room or Hospital
- They are given while You are in a skilled nursing facility and they are ordered by a Participating Provider for a Covered Service and You got the drug or medication through a pharmacy that is in the Molina Healthcare pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

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

Prescription drugs are covered outside of the State of Utah (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) 858-3973 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4128 or contact us with the National Relay Service by dialing 711.

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) 858-3973, Monday through Friday, 9:00 a.m. through 5:00 p.m. MT. If You are deaf or hard of hearing, call toll-free 1 (800) 346-4128 or dial 711 for the National Relay Service. You can also ask us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

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

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask us to keep covering it by sending us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You. Molina Health will cover specific non-Drug Formulary drugs when the prescriber documents in the Your medical record and certifies that the Drug Formulary

alternative has been ineffective in the treatment of the Member's disease or condition, or that the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. Cost Sharing applies to all drugs and medications within the Molina Healthcare Drug Formulary 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.

Formulary Generic Drugs (Tier 1)
Formulary Generic drugs are those drugs listed in the Molina Healthcare Drug Formulary which 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. Costs Sharing for Formulary Generic drugs are listed on the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. You will be charged a Copayment for Formulary Generic Drugs.
If Your doctor orders a brand name drug and there is a Formulary Generic drug available, We will substitute the brand name drug with the Formulary Generic drug.

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.

Formulary Preferred Brand Name Drugs (Tier 2)
Formulary Preferred Brand Name drugs are those drugs listed which, due to clinical effectiveness and cost differences, are designated as "Preferred" in the Molina Healthcare Drug Formulary. Formulary Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and our pharmacy benefit manager. Costs Sharing for Formulary Preferred Brand Name drugs are listed on the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. You will be charged a Copayment for Formulary Preferred Brand Name Drugs.

Formulary Non-Preferred Brand Name Drugs (Tier 3)
Formulary Non-Preferred Brand Name drugs are those drugs listed in the Molina Healthcare Drug Formulary which are designated as "Non-Preferred" due to lesser clinical effectiveness and cost differences. Formulary Non-Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and Our pharmacy benefit manager. Costs Sharing for Formulary Non-Preferred Brand Name drugs are listed on the Molina Healthcare of Utah, Inc. Benefits and Coverage Guide. You will be charged a Coinsurance for Formulary Non-Preferred Brand Name Drugs.

Specialty Oral and Injectable Drugs (Tier 4)
Specialty drugs are prescription legend drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or

- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies.

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

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 (888) 858-3973, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication.

Diabetic Supplies
Diabetic supplies, such as insulin syringes lancets and lancet puncture devices, blood glucose monitors, blood glucose test strips and urine test strips are covered supplies and are provided at Coinsurance Cost Sharing to You. Pen delivery systems for the administration of insulin are also covered and are provided at the Preferred Brand cost share.

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

Prescription Drug and Medication Exclusions
The following are not covered by this product and are excluded from the Prescription Drug Coverage benefit:

- Food supplements, homeopathic medicines and nutritional supplements (prenatal vitamins and folic acid will be covered for pregnancy.
- Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old).
- Hair growth and hair loss products.
- Medications or nutritional supplements for weight loss or weight gain.
- Investigational and non-FDA approved medications.
- Medications needed to participate in any drug research or medication study.
- FDA-approved medication for Experimental or Investigational indications.
- Drugs for athletic and mental performance.
- Oral infant and medical formulas are not covered under the Prescription Drug Coverage benefit.
- Over-the-counter medications and products unless listed in Molina Healthcare's Drug Formulary.

- Medications and injectables prescribed for Industrial Claims and Worker's Compensation.
- Medications dispensed from an institution or substance abuse clinic when the Member does not obtain them from a pharmacy contracted with Molina Healthcare are not payable as a pharmacy claim.
- Compounding fees, powders, and non-covered medications used in compounded preparations.
- Medications used for cosmetic indications.
- Replacement of lost, stolen or damaged medications.
- Nasal immunizations unless listed in the Molina Healthcare Drug Formulary.
- Medications for elective abortions except in accordance with U.C.A. § 31A-22-726.
- Drugs for the treatment of nail fungus.
- Medications for sex change operations.
- Medications needed to treat complications associated with elective obesity surgery and non-Covered Services.
- Drugs used for sexual dysfunction or enhancement.
- Medications for the treatment of infertility.

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):

- Abdominal Binder/Support
- Bilirubin lights up to 7 days
- Brace, back
- Brace limited to 1 per knee per 3 year period
- Brace, leg (child)
- Cast Boot (ambulatory surgical boot)
- Cervical Collar
- Contact lens, following corneal transplant – limit 1per eye
- Contact lens, for keratoconus
- Continuous Passive Motion Machine including supplies-up to 21 days for total knee or shoulder replacement
- Corset (lumbar), custom, orthopedic
- Ear plugs, molds – limit one pair following ear surgery
- Immobilizer, shoulder
- IV Pole
- Lambswool pad
- Lumbosacral Support

- Nebulizer with compressor, ultrasonic, heater etc. – limit one in five years
- 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
- Peak flow meter, handheld – limited to one per plan year
- Rib Belt
- Sling, arm
- Suction pump, aspirator
- Truss
- Wheelchair, armrest replacements
- Wheelchair caster replacements
- Wheelchair, footrest replacement
- Wheelchair, seatbelts, crossbar replacement
- Wheelchair, strap/belt harness replacement
- Wheelchair, tires/tubes, replacement

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

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

Prosthetic and Orthotic Devices

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

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

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

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints if these devices are implanted during

a surgery that is otherwise covered by us. We cover all services and supplies necessary for the effective use such prosthetic device.

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 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
- Prostheses to replace all or part of an external facial body part (including artificial eyes), that has been removed or impaired as a result of disease, injury, or congenital defect

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

HOME HEALTHCARE

We cover these home health care services i.e., health services provided on a part-time, intermittent basis to an individual confines to his or her home due to a physical illness - 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, physical, occupational, or speech therapist and up to four hours per visit by a home health aide
- The Home Healthcare benefit limit is 30 visits per calendar year (counting all home health visits).

You must have Prior Authorization 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 of Utah, Inc. Benefits and Coverage Guide to determine applicability of this benefit to Your product.

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

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

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

HEARING SERVICES

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

We do cover routine hearing screenings that are Preventive Care Services at no charge

OTHER SERVICES

DIALYSIS SERVICES

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

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina Healthcare.
- A Participating Provider physician provides a written Referral for care at the Health Care Facility

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA INCLUDING OUTSIDE OF THE UNITED STATES
Your Covered Services include Urgent Care Services and Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States. If You need Urgent Care Services while traveling outside the United States, or outside of the Service Area 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 or outside the Service Area, You will be required to pay the non-Participating Provider's charges at the time You obtain those services. You may submit a claim for reimbursement to Molina Healthcare for charges that You paid for Covered Services furnished to You by the Non-Participating Provider. Members are responsible for ensuring that claims and/or records of such services are appropriately translated and that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment/service may also be required for proper reimbursement from Molina.

Your claims for reimbursement for Covered Services should be submitted as follows:

Molina Healthcare of Utah, Inc.
P.O. Box 22630
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 Services and Emergency Services while traveling outside of the Service Area, in accordance with U.C.A. § 31A-22-617 and 45 C.F.R. § 147.138, as applicable. Because these services are performed by a Non-Participating Provider You will only be reimbursed for the allowed amount, which may be less than the amount You were charged by the non-Participating Provider. You will not be entitled to reimbursement for charges for health care services or treatment that are excluded from coverage under this EOC, specifically those identified in "Services Provided Outside the United States or Service Area" in the "Exclusions" section of this EOC.

Adoption Benefits

Molina Healthcare will pay $4,000 payable to the Subscriber in connection with an adoption of a child when an adopted child is placed for adoption with the Subscriber within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the Subscriber, only one adoption indemnity benefit will be paid. The Subscriber shall refund Molina Healthcare the full amount of the benefit paid if the post placement evaluation disapproves the adoption placement and/or a court rules the adoption may not be finalized because of an act or omission of the adoptive parent or parents that affects the child's health or safety. If each adoptive parent has coverage under separate health benefit plans, Molina Healthcare will pay its pro rata share. Adoption benefit is not subject to a deductible.

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.

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 results 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 when provided in connection with occupational therapy and physical therapy.

Cosmetic Services

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

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

Custodial Care

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

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

Dental and Orthodontic Services

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

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.

Certain Durable Medical Equipment

The following are excluded from the Durable Medical Equipment benefit:

- Adaptive devices or aids to daily living
- Air cleaner, purifier
- Alarm systems
- Allergy free blanket, pillow case, or mattress cover
- Ankle foot orthotic (AFO)
- Arch supports, insoles, heel cushions, etc.
- Automatic blood pressure monitor
- Auto-tilt chair
- Bandages
- Bar bell set, dumb bells
- Barrel crawl
- Bathtub lifts
- Bathtub seat/bench/chair
- Bathtub/toilet rails
- Batteries, replacement, any type
- Battery charger
- Bed, air fluidized
- Bed baths (home type)
- Bed board
- Bed Cradle
- Bed pans
- Bed side rails
- Bed wedges, foam slants

- Bed, Hospital, standard semi-electric
- Bed, Hospital, total electric
- Bed, non-Hospital, adjustable
- Bed, oscillating
- Bed, pressure therapy
- Beeper
- Biofeedback device
- BiPAP (including eligible attachments and supplies)
- Blood pressure cuff and/or kit
- Bone growth stimulator (osteogenesis) – purchase
- Bone growth stimulator
- Booster chair, pediatric
- Braille teaching texts
- Brassiere/bra (mastectomy)
- Breast pump
- Cane
- Car seat, adult or pediatric
- Car/van lift, car modifications
- Carafe
- Cervical pillow
- Chair, adjustable (for dialysis only)
- Chest compression vest,
- System generator and hoses
- Circle balance discs
- Cleaning solutions
- Coagulation protime self-testing device (CoaguChek)
- Commode and accessories
- Communicative device, equipment or repair
- Computer systems or components
- Computerized assistive devices
- Contact lens
- Continunus hypothermia machine
- Continuous passive motion (CPM) machine for toe/foot surgeries, including supplies
- Continuous positive airway pressure (CPAP machine—including eligible attachments and supplies)
- Contour chair
- Cranial electro stimulation (CES)
- Crawler, height adjustable
- Crawler, prone
- Crawling coordination training unit
- Crutches—purchase
- Crutches—rental
- Crutches, underarm pad
- Replacement
- Cuff weights
- Dehumidifiers (room or central heating system)
- Deironizer, water purification system
- Dialysis equipment, home

- Diapers
- Drionic machine
- Dynasplint
- Electrodes and accessories for stimulators
- Electronic controlled thermal therapy devices
- Electrostatic machine
- Elevators
- Emesis basins
- EMG machine (biofeedback)
- Enuresis alarm unit
- Environmental control systems
- Erectile aid system (vacuum system)
- Exercise equipment
- Eyeglasses
- Face masks
- Fracture frame
- Gel flotation pads and mattresses
- Grab bars
- Gym Mat
- Hand controls for motor vehicle
- Handgrip replacement (cane, crutch, walker, wheelchair, etc.)
- Head float
- Health Spa
- Hearing aids, hearing devices (other than internally-implanted devices as described in "Prosthetic and Orthotic Devices"
- Heat lamps
- Heating pads, hot water bottle
- Home modifications
- Home physical therapy kits
- Hot tub
- Humidifier
- Humidifier, room or central heating
- Humidifier, only with IPPB or other respiratory equipment
- H-Wave electronic device, including supplies
- Hydraulic patient lifts
- Hydrocollater unit
- Hydrotherapy tanks
- Ice Packs
- Incontinence treatment system
- Interferential nerve stimulator
- IPPB machine
- Kangaroo pump/kit
- Lift platform, wheelchair, van or home
- Lift, chair (seat)
- Light box (seasonal)
- Limb Prosthetics
- Lymphedema pump (pneumatic compressor)
- Lymphedema sleeves/supplies

- Maclaren buggy, stroller
- Maintenance, warranty or service contracts
- Maintenance/repair, routine
- Massage devices
- Mattress, Hospital bed
- Mattress, inner spring or foam rubber
- Mattress, pressure-reducing, including overlay
- Motor vehicle
- Motor vehicle alterations, conversions
- Motor vehicle devices, hand controls, lifts, etc.
- Mouth guard
- Muscle stimulator, including supplies
- Myoelectric prosthetics
- Neo-control chair
- Neuromuscular stimulator (NMES)
- Oral appliance to treat obstructive sleep apnea
- Orthopedic brace for sports activities
- Orthotics, shoe inserts (any type)
- Overbed tables
- Oxygen systems, concentrators and accessories—purchase
- Pager
- Paraffin bath units (therabath)
- Parallel bars
- Pelvic floor stimulator
- Percussor, chest (with generator)
- Polarcare (cold compression device)
- Portable room heaters
- Postural drainage board
- Posture chair
- Pressure pads, cushions and mattresses (with or without pumps)
- Prosthesis, limb
- Prosthetic socks (stump socks), and supplies
- Protonics knee orthosis
- Pulsed galvanic stimulator, including supplies
- Quad-cane
- Raised toilet seats
- Reflux board, infant
- Repairs, non-routine performed by a skilled technician
- Rocking bed
- Roho air flotation system
- Rollabout chair
- Rowing machine
- Safety grab bar, rail, bathroom, toilet, bed
- Safety rollers, with walkers
- Sauna baths
- Scales
- Scooter board
- Seat lift mechanism

- Shoes, orthopedic or corrective, modifications, lifts, heels, wedges, inserts, etc.
- Shower bench
- Sitz bath
- Spa membership
- Speech augmentation communication device
- Speech generating device
- Speech teaching machines, language master
- Sphygmomanometer with cuff (blood pressure cuff)
- Spinal pelvic stabilizers
- Stairglide (stairway elevator lift)
- Stander
- Standing table
- Stethoscope
- Sun glasses
- Support hose (elastic stockings, surgical stockings)
- Support Pillow
- Swimming Pool
- Sympathetic therapy
- Stimulator (STS), including supplies
- Telephone
- Telephone alert systems
- Telephone arms
- Theraband
- Therapy ball, roll, putty
- Thermometer
- Tips, replacement (wheelchair, walker, crutches, etc.)

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 the diagnosis and treatment 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.

Mental Health and Substance Abuse

The following are excluded from coverage, whether delivered in an outpatient, inpatient, or other setting:

- Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
- Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
- Wilderness programs.
- Inpatient treatment for behavior modification, enuresis, or encopresis.
- Psychological evaluations or testing for legal purposes such as custodial rights, etc., or

for insurance or employment examinations.
- Occupational or recreational therapy.
- Hospital leave of absence charges.
- Sodium amobarbital interviews.
- Residential treatment programs.
- Routine drug screening, except when ordered by a treating physician.

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, except that this exclusion does not apply when the overnight stay is part of covered care in a Hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental 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 FDA

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA. 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 that are performed by people who do not require licenses or certificates by the state to provide health care services are not covered.

Services Provided Outside the United States or Service Area

Any services and supplies provided to a Member outside the United States or the service area 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 Physicians care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area unless they are Urgent Care Services or Emergency Services furnished to a Member while traveling.

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

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 toll-free at 1 (888) 858-3973. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4128 or dial 711 for the National Relay Service.

THIRD-PARTY LIABILITY

You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, 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 Utah law or rule immediately upon collection of damages by him or her, whether by action ,law or rule, 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 Utah law or rule Molina Healthcare's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

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

WORKERS' COMPENSATION

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

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

RENEWAL AND TERMINATION

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

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina Healthcare. Except that if a change to the Agreement (1) reduces benefits or coverages under the Plan; or (2) increases the premium during the term of this Plan, Molina will send a notice to the Subscriber which requires the Subscriber's signed acceptance.

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, 2015, Your last minute of coverage was at 11:59 p.m. on June 30, 2015). 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.

If We rescind Your coverage You may have the right to have Our decision reviewed by a health care professional who has no association with us if Our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment You requested. To receive additional information about an independent review, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City UT 84114; by phone at 801 538-3077; or electronically at healthappeals.uid@utah.gov.

Your membership with Molina Healthcare will terminate if You:

- **Cancel Your Coverage Within 10 Days**: You have 10 calendar days to examine this EOC. You may cancel Your Coverage within 10 days of Your signing this Agreement and Molina Healthcare will refund Your Premium. If Covered Services are received by any Member during this 10-day examination period, then the Subscriber must pay the full cost of those Covered Services if his or her premium has been returned.

- **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 a notice of termination when it learns You no longer live or work in Molina Healthcare's Service Area for this product. 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) if You timely cancel Your coverage under this EOC within 10 calendar days of You signing it; (iii) within the first 60 calendar days from the Effective Date of Your coverage if You are not satisfied with Molina Healthcare, or (iii) during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace's special enrollment procedures, or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage

with Molina Healthcare, in which case a notice of termination will be sent and Your membership will end at 11:59 p.m. on the seventh day from the date the notice of termination is mailed. Some examples include:

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

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

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 and, as a result, such Member's coverage under those specific Benefits and Coverage will terminate on his or her 19th birthday, without affecting the remainder of this 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 the coverage month or earlier if so stated in Your Premium bill. This is the "**Due Date.**" Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Molina Healthcare does not receive the full Premium payment due on or before the Due Date stated in Your Premium bill, Molina Healthcare will send a notice of non-receipt of Premium payment and cancellation of coverage (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:

    - A statement that Molina Healthcare has not received full Premium payment and that We

will terminate this Agreement for nonpayment if We do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
- The amount of Premiums due.
- The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if We do not receive the required Premiums.

If Molina does not receive the full Premium payment due on or before the Due Date, as described above, We Molina will give You either a:

- 30-day grace period to pay the full Premium payment due if You are not receiving advance payment of the premium tax credit; or,
- Three (3) month grace period to pay the full Premium payment due if You are receiving advance payment of the premium tax credit. Molina will pend payment for Covered Services received after the first month of the grace period until We receive all delinquent Premiums. If all Premiums are not received, in full, by the end of the three-month grace period, You will be responsible for payment of the Covered Services received by You and any enrolled Dependents during the second and third months of the grace period.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe to Molina. If You do not pay the full Premium payment due and owing by the end of the grace period applicable to You, this Agreement will be terminated. You will still be responsible for any unpaid Premiums You owe Molina for the grace period if You receive advance payment of the premium tax credit.

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

- On the last day of the month prior to the beginning of the grace period if You are not receiving advance payment of the premium tax credit; or,
- On the last day of the first month of the grace period if You are receiving advance payment of the premium tax credit.

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

YOUR RIGHTS AND RESPONSIBILITIES

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

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 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 or rules.
- 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 Federal laws, and State laws or rules

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) 858-3973.
- 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 Health Care
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) 858-3973, Monday through Friday, between 9:00 a.m. and 5:00 p.m. MT.

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) 858-3973 for more information.

Member Participation Committee

We want to hear what You think about Molina Healthcare. Molina Healthcare has formed the Member Participation Committee to hear Your concerns.

The Committee is a group of people just like You that meets once every three (3) months and tells us how to improve. The Committee can review health plan information and make suggestions to Molina Healthcare's Board of Directors. If You want to join the Member Participation Committee, please call Molina Healthcare toll-free at 1 (888) 858-3973, Monday through Friday, 9:00 a.m. to 5:00 p.m. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4129 or dial 711 for the National Relay Service. Join Our Member Participation Committee today!

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. That is why Molina Healthcare has a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

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

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

WHAT DO I HAVE TO PAY FOR?

Please refer to the "Molina Healthcare of Utah, Inc. Benefits and Coverage Guide" 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.
- Except in the case of Emergency or out of area Urgent Care Services, You ask for and get health care services from a doctor or Hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare

If Molina Healthcare fails to pay a Molina Healthcare contracted provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the 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.

WHAT IF I HAVE PAID A MEDICAL BILL OR PRESCRIPTION?

(REIMBURSEMENT PROVISIONS)

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

After We receive Your letter, We will respond to You within 30 days. If Your claim is accepted, We will mail You a check. If not, We will send You a letter telling You why. If You do not agree with this, You may appeal by calling Molina Healthcare toll-free at 1 (888) 858-3973, Monday through Friday, 9:00 a.m. to 5:00 p.m. MT.

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) 858-3973, Monday through Friday, 9:00 a.m. to 5:00 p.m. MT. You may also call Your provider's office or Your provider's medical group for this information.

COORDINATION OF BENEFITS

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

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

Definitions (applicable to this COB provision)

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

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured) ; medical care components of long-term care contracts, such as skilled

nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules-

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

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

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

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

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

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

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

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

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

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

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

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

- • The Plan covering the Custodial Parent;

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

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

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D. (1) can determine the order of benefits.

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

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

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

Effect On The Benefits Of This Plan

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

If You believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting us. Follow the steps described in the "Complaints" section, below. If You are still not satisfied, You may call the Utah Insurance Department, Health Insurance Division, Consumer Services for instructions on filing a consumer complaint. Call (801) 538-3077, or visit Utah Insurance Department, Health Insurance Division, Consumer Services website at www.insurance.utah.gov.

ADVANCE DIRECTIVES

An Advance Directive is a form that tells medical providers what kind of care You want if You cannot speak for Yourself. An Advance Directive is written before You have an Emergency. This is a way to keep other people from making important health decisions for You if You are not well enough to make Your own. A "Durable Power of Attorney for Health Care" or "Natural Death Act Declaration" are types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives.

You may call Molina Healthcare to get information regarding State law or rule on Advance Directives, and changes to Advance Directive laws. Molina Healthcare updates advanced

directive information no later than 90 calendar days after receiving notice of changes to State laws or rules.

For more information, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3973. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 346-4128 or dial 711 for the National Relay Service.

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) 585-3973, Monday through Friday, 9:00 a.m. - 5:00 p.m. MT. Deaf or hard of hearing Members may call Our toll-free TTY number at 1 (800) 346-4129. You may also contact us by calling the National Relay Service at 711 if You are deaf or hard of hearing.
- You may also send us Your problem or complaint in writing by mail or filing online at Our website. Our address is:

  Molina Healthcare
  Complaints and Appeals
  7050 Union Park Center, Suite 200
  Midvale, UT, 84047
  www.molinahealthcare.com

  Or You may contact the Utah Insurance Department Consumer Services

  Utah Insurance Commissioner
  Suite 3110
  State Office Building
  Salt Lake City UT 84114
  801 538-3077
  healthappeals.uid@utah.gov

APPEALS

Definitions

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

"Adverse Benefit Determination": means

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

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

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

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

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

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

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

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

"UID": means the Utah Insurance Department.

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

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

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

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

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

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

Internal Appeal

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

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

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

Molina Healthcare of Utah, Inc.
Attn: Grievance and Appeals Coordinator
7050 Union Park Center, Suite 200
Midvale, UT 84047

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

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

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

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

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

Exhaustion of Process

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

General Rules and Information

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

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

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

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

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

Telephone Numbers and Addresses

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

Utah Insurance Commissioner
Suite 3110
State Office Building
Salt Lake City UT 84114
801 538-3077
healthappeals.uid@utah.gov

Molina Healthcare of Utah, Inc.
Attn: Complaints and Appeals Coordinator
7050 Union Park Center, Suite 200
Midvale, UT 84047
www.molinahealthcare.com

INDEPENDENT REVIEW PROCESS

You may request an independent review of an Adverse Benefit Determination only after exhausting the Molina Healthcare's internal review process described above unless: (1) Molina Healthcare agrees to waive Our internal review process; (2) Molina Healthcare has not complied with the requirements of Our review process, except where those failures are de minimus violations that do not cause, and are not likely to cause, prejudice or harm to the Member and are not part of a pattern or practice failing to follow the requirements; or (3) You have requested an expedited independent review at the same time You requested an expedited internal review.

Rules That Apply to All Independent Review Requests

Molina will pay the cost for an independent review organization to conduct a review of an Adverse Benefit Determination. You may request an independent review at regardless of the dollar amount of the claim or services involved.

You must file a request with the Utah Insurance Commissioner for an independent review no later than 180 days after You receive the Final Adverse Benefit Determination notice from Molina Healthcare. If You send the request to Molina Healthcare, We will forward the request to the Utah Insurance Commissioner within 1 business day of receipt. You must use the Independent Review Request Form available at www.insurance.utah.gov, or from the Customer Support Center at (800) 858-3973 to file the request.

The independent review request must contain an authorization for the necessary parties to obtain medical records for purposes of making a decision on the independent review request.

The independent review decision is binding on Molina Healthcare and the Member except to the extent that other remedies are available under federal law and state laws or rules.

Rules That Apply to a Standard Independent Review Requests

Upon receipt of the Independent Review Request Form, the Utah Insurance Commissioner will send a copy of the request to Molina Healthcare. Within five business days following receipt of the request, Molina will determine whether: (a) the individual was a Member at the time of rescission or the health care service was requested or provided; (b) a health care service that is the subject of an Adverse Benefit Determination is a covered service; (c) the Member has exhausted Molina Healthcare's internal review process described above; and (d) the Member has provided all the information and forms required for the independent review.

Within one business day of making these determinations, Molina Healthcare will notify the Utah Insurance Commissioner and You in writing whether the request is complete and eligible for independent review. If the request is not complete, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing what information or materials are need to make the request complete.

If the request is not eligible for independent review, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing of the reasons why the request is not eligible for independent review and inform the Member that the determination may be appealed to the Utah Insurance Commissioner. The Utah Insurance Commissioner may decide in accordance with the terms of this EOC that the request is eligible for independent review despite Molina Healthcare's determination that the request is not eligible in which case the request will be independently reviewed.

If a request is eligible for independent review, the Utah Insurance Commissioner will:

- Assign on a random basis an independent review organization from the list of approved independent review organization based on the nature of the health care service that is subject to review;
- Notify Molina Healthcare of the assignment and require Molina Healthcare to provide to the independent review organization the documents and any information considered in making the Adverse Benefit Determination within 5 business days; and

- Notify You that the request has been accepted and You may submit additional information to the independent review organization within 5 business days of receipt of the Utah Insurance Commissioner's notice. The independent review organization will forward to Molina Healthcare within 1 business day of receipt any information submitted by You.

The independent review organization will provide notice of its decision to uphold or reverse the Adverse Benefit Determination within 45 calendar days to You, Molina Healthcare and the Utah Insurance Commissioner. If the Adverse Benefit Determination is reversed, Molina Healthcare will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within one business day of the notice.

Rules that Apply to Expedited Independent Review Requests

An expedited independent review is available when the Adverse Benefit Determination:

- Involves a medical condition which would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;
- In the opinion of the Member's attending provider, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination; or
- Concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services, but has not been discharged from a facility.

Upon receipt of the Independent Review Request Form, the Utah Insurance Commissioner will immediately send a copy of the request to Molina Healthcare. Immediately upon receipt, Molina Healthcare will determine whether : (a) the individual was a Member at the time the health care service was requested or provided; (b) a health care service that is the subject of an Adverse Benefit Determination is a covered service; and (c) the Member has provided all the information and forms required for the expedited independent review.

Molina Healthcare will immediately notify the Utah Insurance Commissioner and You whether the request is complete and eligible for expedited independent review. If the request is not complete, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing what information or materials are need to make the request complete.

If the request is not eligible for expedited independent review, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing of the reasons why the request is not eligible for expedited independent review and inform You that the determination may be appealed to the Utah Insurance Commissioner. The Utah Insurance Commissioner may decide in accordance with the terms of this EOC that the request is eligible for expedited independent review despite Molina Healthcare's determination that the request is not eligible in which case the request will be independently reviewed

If a request is eligible for expedited independent review, the Utah Insurance Commissioner will:

- Assign on a random basis an independent review organization from the list of approved independent review organization based on the nature of the health care service that is subject to review;
- Notify Molina Healthcare of the assignment and require Molina Healthcare within 1 business day to provide to the independent review organization the documents and any information considered in making the Adverse Benefit Determination; and

- Notify You that the request has been accepted and You may submit additional information to the independent review organization within 1 business day of receipt of the Utah Insurance Commissioner's notice. The independent review organization will forward to Molina Healthcare within 1 business day of receipt any information submitted by You.

The independent review organization will as soon as possible, but not later than 72 hours after receipt of the request for an expedited independent review, provide notice of its decision to uphold or reverse the Adverse Benefit Determination to You, Molina Healthcare and the Utah Insurance Commissioner. If the notice is not in writing, the independent review organization must provide written confirmation of its decision within 48 hours after the date of notification of the decisions. If the Adverse Benefit Determination is reversed, Molina Healthcare will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within one business day of the notice.

RULES THAT APPLY TO INDEPENDENT REVIEW REQUESTS BASED ON EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR TREATMENTS

If You submit a request for independent review involving experimental or investigational service or treatment, the request must contain a certification from the Member's physician that: (a) standard health care service or treatment has not been effective in improving the Member's condition; (b) standard health care services or treatments are not medically appropriate for the Member; or (c) there is no available standard health care service or treatment covered by the Plan that is more beneficial than the recommended or requested health care service or treatment.

Upon receipt of the Independent Review Request Form involving experimental or investigation services or treatments, the Utah Insurance Commissioner will send a copy of the request to Molina Healthcare. Within five business days, or one business day for expedited requests, following receipt of the request, Molina will determine whether : (a) the individual was a Member at the time the health care service was requested or provided; (b) the health care service that is the subject of an Adverse Benefit Determination is a covered service, except that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit in the EOC; (c) You has exhausted Molina's internal review process described above, unless the request is for an expedited review; and (d) You have provided all the information and forms required for the independent review.

Within one business day of making these determinations, Molina Healthcare will notify the Utah Insurance Commissioner and You in writing whether the request is complete and eligible for independent review. If the request is not complete, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing what information or materials are need to make the request complete.

If the request is not eligible for independent review, Molina Healthcare will inform You and the Utah Insurance Commissioner in writing of the reasons why the request is not eligible for independent review and inform You that the determination may be appealed to the Utah Insurance Commissioner. The Utah Insurance Commissioner may decide in accordance with the terms of this EOC that the request is eligible for independent review despite Molina Healthcare's determination that the request is not eligible in which case the Utah Insurance Commissioner will the request will be independently reviewed.

If a request is eligible for independent review, the Utah Insurance Commissioner will:

- Assign on a random basis an independent review organization from the list of approved independent review organization based on the nature of the health care service that is subject to review;
- Notify Molina Healthcare of the assignment and require Molina Healthcare within five business days, or one business day for a request for expedited review, to provide to the independent review organization the documents and any information considered in making the Adverse Benefit Determination; and
- Notify You that the request has been accepted and You may submit additional information to the independent review organization within 5 business days, or one business day for expedited review requests, of receipt of the Utah Insurance Commissioner's notice. The independent review organization will forward to Molina Healthcare within one business day of receipt any information submitted by You.

Within one business day of receipt of the request, the independent review organization will select a one or more clinical reviews to conduct the review. The clinical reviewer will provide the independent review organization a written opinion with 20 calendar days, or five calendar days for an expedited review, after being selected.

The independent review organization will make a decision based on the clinical reviewer's opinion within 20 calendar days of receipt of the opinion, or 48 hours in the case of an expedited review, and provide notice of its decision the Member, Molina and the Utah Insurance Commissioner. If the Adverse Benefit Determination is reversed, Molina will approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due within one business day of the notice.

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) 858-3973.

Organ or Tissue Donation
You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by contacting the Department of Motor Vehicles or The Utah Donor Registry at www.yesutah.org.

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

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

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

Proof of Loss
If required or appropriate as determined by Molina Healthcare, written proof of loss relating to a Claim must be furnished to Molina at its office (identified in the "Notice of Claim" section above) within 365 days after the occurrence or start of the loss on which the Claim is based to validate and preserve the Claim. If written proof of loss is not given within that time, the Claim will not be invalidated, denied or reduced if it is shown that written proof of loss relating to a Claim was given as soon as was reasonably possible or legal incapacity of the Member extended the time period for providing such proof of loss. Foreign Claims and proof of loss relating to such Claims must be translated in U.S. currency prior to being submitted to Molina Healthcare.

HEALTH MANAGEMENT AND HEALTH EDUCATION

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

HEALTH MANAGEMENT

Molina Healthcare offers many programs to help keep You and Your family healthy. You may ask for booklets on topics such as:

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

You can also enroll in any of these programs by calling the Molina Health Management Department at 1 (888) 858-3973, between 9:30 a.m. and 5:30 p.m., Monday through Friday.

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

Call toll-free 1 (888) 858-3973 (Monday through Friday, 9:30 a.m. – 6:30 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 pregnancy book that You can use as a reference throughout Your pregnancy..

You will be able to talk with Our caring staff about any questions You may have during Your 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 Your 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 Include

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

HEALTH EDUCATION

Molina's Health Education Department is committed to helping You stay well. Find out if You are eligible to sign up for one of Our programs. Call toll-free **1 (866) 472-9483** between 9:30 a.m. and 6:30 p.m. MT, Monday through Friday. Ask about other services We provide or request information to be mailed to You.

The following are a list of health education programs and services Molina has to offer You.

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.

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.

Diabetes Self-Management Training
We cover diabetes self-management training programs designed to help individuals to learn to manage their diabetes in an outpatient setting including nutrition therapy. Nutrition therapy means the assessment of patient nutritional status followed by therapy including diet modification, planning and counseling services which are furnished by a registered licensed dietitian.

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 9:00 a.m. to 5:00 p.m. MT. When in doubt, call us first.	**Customer Support Center Toll Free:** 1 (888) 858-3973 **TTY line for the deaf or hard of hearing:** 1 (800)346-4128 or dial 711 for the National Relay Service
Health Management	To request any information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes.	1 (888) 858-3973 between 9:30 a.m. and 6:30 p.m.
Health Education	To request information on wellness, including smoking cessation and weight management.	**1 (866) 472-9483** between 9:30 a.m. and 6:30 p.m.
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 **for Spanish:** at 1 (866) 648-3537
Motherhood Matters®	Molina Healthcare offers a special program called **Motherhood Matters®** to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that We have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(800) 368-1019 **TDD for deaf or hard of hearing:** (800) 537-7697 **FAX:** (303) 844-2025
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**
Utah Insurance Department, Health Insurance Division, Consumer Services	The Utah Insurance Department is responsible for regulating health care services plans. If You have a complaint against Your health plan, You should first call Molina Healthcare toll-free at 1-888-858-39731, and use Molina Healthcare's grievance process before contacting this department.	(801) 538-3077 TDD: (801) 538-3826 http://www.insurance.utah.gov Email: health.uid@utah.gov