2019

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

Molina Marketplace – Silver 250 Plan

UTAH

7050 Union Park Center, Suite 200, Midvale, Utah 84047

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN NATIVE THAT HAS A COST SHARING REQUIREMENT IN YOUR PLAN, THEN 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.

MolinaMarketplace.com

MOLINA® HEALTHCARE
Your Extended Family.

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MOLINA HEALTHCARE OF UTAH, INC.
SCHEDULE OF BENEFITS

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF 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.

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

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$5,350
Entire Family of 2 or more	$10,700
Prescription Drug Deductible (Cost Sharing maximums apply to Oral Chemotherapy)	
Individual	$400
Entire Family of 2 or more	$800

Annual Out of Pocket Maximum[1]	**At Participating Providers, You Pay**
Individual	$7,900
Entire Family of 2 or more	$15,800

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

Emergency Services and Urgent Care Services[2]		**You Pay**
Emergency Room[3] **(Applies to Facility Charges Only)**	30%	Coinsurance after Deductible
Urgent Care	$50	Copayment per visit

[2] You may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Emergency Services rendered by a Non-Participating Provider. Please refer to the section of the Agreement titled "Emergency Services and Urgent Care Services" for more information.

[3] 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 [4]	At Participating Providers, You Pay	
Office Visits[5]		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care and Other Practitioner Care	$30	Copayment per visit
Specialty Care	$75	Copayment per visit
Habilitative Services and Rehabilitative Services Habilitative and Rehabilitative Services benefits have a combined limit of 20 visits per calendar year. Member Cost Sharing and visit limits shown apply in any place of service.	$75	Copayment per visit
Mental Health Services	$30	Copayment per visit
Substance Abuse Services	$30	Copayment per visit
Phenylketonuria (PKU)		
Preventive Care Screening for Children	No Charge	
Testing and Treatment of PKU	$30	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	

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

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

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgery and Other Procedures		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Chemotherapy Services and Provider-Administered Drug	30%	Coinsurance after Deductible
Radiation Services	30%	Coinsurance after Deductible
Specialized Scanning Services (CT Scan, PET Scan, MRI) Unless these services are performed while You are in an inpatient setting, Your Cost Sharing amount for these services will apply.	30%	Coinsurance after Deductible
Radiology Services	$75	Copayment
Laboratory Services	$40	Copayment
Mental Health Outpatient Intensive Psychiatric Treatment Programs	30%	Coinsurance after Deductible

Inpatient Hospital Services	At Participating Providers, You Pay	
Medical / Surgical		
Professional	30%	Coinsurance after Deductible
Facility	30%	Coinsurance after Deductible
Maternity Care (professional and facility services)	30%	Coinsurance after Deductible
Mental Health (Inpatient Psychiatric Hospitalization)	30%	Coinsurance after Deductible
Substance Abuse	30%	Coinsurance after Deductible
Inpatient Detoxification	30%	Coinsurance after Deductible
Transitional Residential Recovery Services	30%	Coinsurance after Deductible
Transplant Services	30%	Coinsurance after Deductible
Skilled Nursing Facility (30 days per calendar year)	30%	Coinsurance after Deductible
Hospice Care (limited to 6 months in a 3 year period)	No Charge	

Prescription Drug Coverage[6]	At Participating Providers, You Pay	
Tier-1 Drugs	$20	Copayment
Tier-2 Drugs	$60	Copayment
Tier-3 Drugs	40%	Coinsurance after Deductible
Tier-4 Drugs	40%	Coinsurance after Deductible
Mail-Order Prescription Drugs	Up to a 90-day supply is offered at two times the one-month retail prescription benefit Cost Sharing.	

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

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment (including Prosthetic Devices)	30%	Coinsurance
Home Healthcare (30 visits per calendar year)[7]	No Charge	

[7] Services must be billed by a Home Healthcare Participating Provider agency. Separate Cost Sharing may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.).

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

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

Other Services	At Participating Providers, We Pay	
Adoption Indemnity Benefit[8]	$4,000	Per Adoption

[8] 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 the section titled Adoption Benefits for a description of Adoption Benefits and restrictions.

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Subscriber may cancel 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 Covered Services as described in this Agreement.

This Agreement, and amendments to this Agreement, and any application(s) submitted to the Marketplace and/or Molina Healthcare 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 in the section titled "Renewal and Termination" in this document.

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 Agreement, call Us. You can call Us if You want to know more about Molina. You can get this information in another language, large print, Braille, or audio. To request a copy of the Agreement You may call or write to Us at:

Molina Healthcare of Utah, Inc.
7050 Union Park Center, Suite 200
Midvale, UT 84047
1 (888) 858-3973
MolinaMarketplace.com

Members with speech or hearing impairment may contact us by dialing 711 for the National Telecommunication Service.

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. It also sets out the terms and conditions of coverage under this Agreement. It tells You Your rights and responsibilities as a Molina Member. It explains how to contact Molina. Please read this EOC completely and carefully. Keep it in a safe place where You can get to it quickly. There are sections for special health care needs.

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

- Arrange for an interpreter
- Check on Authorization Status
- Choose a Primary Care Provider
- Make an appointment
- Make a Payment

We can also listen and respond to any of Your questions or complaints about Your Molina product.

Call us toll-free at 1 (888) 858-3973. TTY users may dial 711

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

Please contact Our Customer Support Center to update that information.

Sharing Your updated address and phone number with Molina. 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.

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.

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

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

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

All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service, 100% of the published Medicare rate for such service, Molina's usual and customary rate for such service, or a negotiated amount agreed to by the Non-Participating Provider and Molina.

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

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

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

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

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

"**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. Schedule of Benefits. 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. Schedule of Benefits. 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. Schedule of Benefits at the beginning of this EOC.

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

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

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

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

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

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

"**Prior Authorization**" means Molina's prior determination for Medical Necessity of Covered Services before services are provided. Prior Authorization is not a guarantee of payment for services. Payment is

made based upon the following;

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

"**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 legally recognized husband, wife, domestic, or life Partnership.

"**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.

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

Telehealth and Telemedicine Services means:

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

"**Urgent Care Services**" 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. It is the date You are accepted by the Marketplace and/or Molina.

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

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

If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period. You must be eligible under the special enrollment procedures established by the Marketplace and/or Molina and your reason for eligibility must be verified with documentation that is acceptable to the Marketplace and/or Molina. In such case, the Effective Date of coverage will be determined by the Marketplace. The Marketplace and/or Molina will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

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

Who is Eligible?
To enroll and stay enrolled You must meet all of the eligibility requirements. These are set by the Marketplace Exchange. Check the Marketplace Exchange website at healthcare.gov for these requirements. Molina requires You to live in Our Service Area for this product. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. Molina requires Members to live in Molina's Service Area for this Agreement. If You have lost Your eligibility, You may not be able to re-enroll. This is described in the section titled "When Will My Molina Membership End? (Termination of Covered Services)."

Dependents: Subscribers who enroll Agreement during the open enrollment period established by the Marketplace Exchange may also apply to enroll eligible Dependents. This is established by the Marketplace Exchange. Dependents must meet the eligibility requirements. Dependents must live in Our Service Area for this product. The following family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children, stepchildren and foster children). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.

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

Age Limit for Disabled or Handicapped Children (also known as ward): Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if each 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.

A disabled child may remain covered by Molina as a Dependent. This applies as long as he or she remains incapacitated. The child must initially meet and continue to meet the above-described eligibility criteria described.

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, newly adopted child, Foster Child, or a child only dependent), You must contact the Marketplace Exchange and/or Molina and submit any required application(s), forms and requested information for the Dependent.

Your requests to enroll a new Dependent must be submitted to the Marketplace Exchange and/or Molina within 60 days from the date the Dependent became eligible to enroll with Molina.

Spouse: You can add a Spouse as long as You apply during the open enrollment period.

You can also apply no later than 60 days after any event listed below:

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

Children Under 26 Years of Age: You can add a Dependent under the age of 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than30 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, placement for adoption, placement in foster care, adoption, placement for adoption, child support, or other court order.
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The child permanently moves into the service area.
-

Newborn Child: Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 30 days, the newborn is covered for only 30 days (including the date of birth). Enrollment within 30 days will require additional premium to be charged because of the addition of the child up to three oldest covered children under 21 for a family coverage.

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

Court Order to Provide Child Coverage: When a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage under this Agreement, Molina shall:

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

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

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

Discontinuation of Dependent Covered Services: Covered Services for Your Dependent will be discontinued on:

- The end of the calendar year that the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children Age Limit for Disabled or Handicapped Children."
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage from the Subscriber.
- The date the Dependent Domestic Partner enters a termination of the domestic partnership from the Subscriber.
- End of the month that the child only Member is no longer eligible.

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

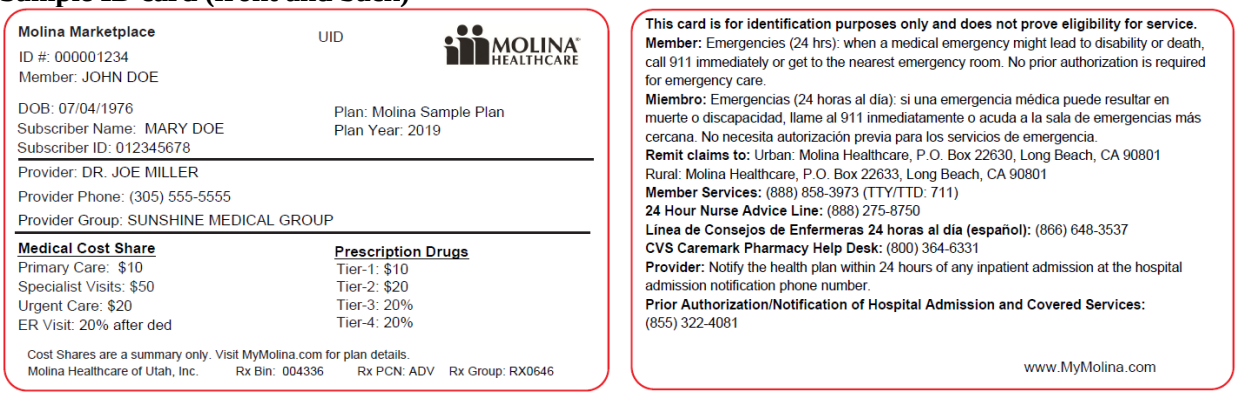
- The Member becomes abusive or violent and threatens the safety of anyone who works with Molina Healthcare, including Participating Providers.
- The Member substantially impairs the ability of Molina Healthcare, or anyone working with Molina Healthcare, including Participating Providers, to provide care to the Member or other Members.
- There is a breakdown in the Member's relationship with the Member's doctor and Molina 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 card (ID card) from Molina. Your ID card comes in the mail within 10 business days after You make your first payment. Your ID card lists Your 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 toll-free at 1 (888) 858-3973. We will be happy to send You a new ID card.

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

Sample ID card (front and back)



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

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Your Primary Care Provider's name (Provider)
- Your Primary Care Provider'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
- Toll free number to notify Molina Healthcare of emergency room admissions for Our Members Emergencies (24 hrs.) when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
- If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3973.

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.

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 **MolinaMarketplace.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, 2014.

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

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

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

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

For Health Care Operations
Molina Healthcare may use or share 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
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

ACCESSING CARE

How Do I Get Medical Services Through Molina?
(Choice of Doctors and Participating 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 Participating Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina. You may visit Molina's website at **MolinaMarketplace.com** to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

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

If You need hospital or similar services, You must go to a Health Care Facility that is a Participating Provider. For more information about which facilities are with Molina or where they are located, call Molina toll-free at 1 (888) 858-3973. You may get Emergency Services or out of area Urgent Care Services in any emergency room or urgent care center, wherever located.

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

- for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services,"
- for out-of-area Urgent Care Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services," and
- for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

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

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

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. To find the service You need, look in the box just to the right of it, and You will find out where to go.

Always consult Your Primary Care provider first, except for Emergencies.	
TYPE OF HELP YOU NEED:	**WHERE TO GO. WHO 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. For Spanish, select option 1. Only Participating Provider urgent care centers are covered. For out-of-area Urgent Care Services You may also go to the nearest emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization 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's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a mental health or substance abuse Participating Provider. You do not need a Referral or Prior Authorization to get a mental health or substance abuse evaluation.
For mental health or substance abuse therapy	For mental health or substance abuse therapy, a Referral from your mental health Participating Provider is not needed.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. Your PCP will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Services, get help as directed under Emergency Care or Urgent Care Services above
To have surgery	Go to Your PCP first. 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	Go to Your PCP for a Referral. Consult Your Provider Directory on Our website at **MolinaMarketplace.com** to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. Your PCP 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 urgent care center. You can also call Molina's Nurse Advice Line toll-free at 1 (888) 275-8750. For Spanish, select option 1.

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

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

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

If You want to know more about Your PCP or other Molina doctors, call Us. Molina's Customer Support Center number is 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 provided by Molina Healthcare Participating Providers (doctors, hospitals, Specialist Physicians or medical clinics), except in the case of Emergency Services or out of area Urgent Care Services. Please see section Emergency Services and Urgent Care Services for more information about the coverage of Emergency Services and out of area Urgent Care Services. If Medically Necessary Covered Services are not available through a Participating Provider, You may request Prior Authorization to allow referral to a non-Participating Provider for the specifically requested medical condition. Upon Medical Necessity review, approved authorizations will be treated as a Participating Provider Covered Service. We will reimburse the non-Participating Provider up to Molina's Allowed Amount for such 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's health plan. You will also learn some helpful tips on how to use Molina's services and benefits. Visit Molina's website at **MolinaMarketplace.com** to view Our online list of participating providers, or call Molina Healthcare toll-free at 1 (888) 858-3973 to receive a printed copy.

You can find the following in Molina's 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, hospitals, Specialist Physicians, or medical clinics.

You can also find out if a Participating Provider, including doctors, hospitals, Specialist Physicians, or medical clinics, is accepting new patients in Your Participating Provider Directory.

Note: Some hospitals and participating providers may not provide some of the services that may be covered under this EOC that You or Your family member might need. This may include family planning, women's contraceptive methods approved by the FDA, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should get 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 is 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 You 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. You may choose a pediatrician to be Your children's PCP.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina toll-free at 1 (888) 858-3973. Molina can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina doctor.

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

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

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

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

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

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

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. A good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina doctor.

Can my Primary Care Provider request that I change to a different Primary Care Provider?

Your Primary Care Provider 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. We are here, Monday through Friday, 9:00 a.m. to 5:00 p.m. MT. You may also visit Molina's website at **MolinaMarketplace.com** to view Our online list of doctors. Let Us help You make the change.

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

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

What if my doctor or hospital is not with Molina?
If Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina Healthcare, We will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. Our Molina Healthcare Customer Support Center staff can help You make a choice.

If You are assigned to a PCP or hospital that is ending a contract with Molina Healthcare, then Molina Healthcare will provide You 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 for continuity of care, call Molina's Customer Support Center toll-free at 1 (888) 858-3973. TTY users may dial 711.

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

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

If Covered Services are not reasonably available by Participating Providers, Molina will evaluate the Medical Necessity of such services requested by Your PCP, Specialist or Other Practitioner, and if warranted provide access to Non-Participating Providers as Covered Services for the specifically requested medical condition, up to Molina's Allowed Amount for such services.

In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

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

- Medically Necessary
- Prior Authorized
- A Covered Service

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

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

Continuity of Care
If You are receiving an Active Course of Treatment for Covered Services from a Participating Provider whose participation with Molina is ending without cause, You may have a right to continue receiving Covered Services from that provider until the Active Course of Treatment is complete or for 90 days, whichever is shorter, at in-network Cost Sharing.

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

An "Active Course of Treatment" is:

- an ongoing course of treatment for a Life-Threatening Condition;
- an ongoing course of treatment for a Serious Acute Condition;
- the second or third trimester of pregnancy through the postpartum period; or
- an ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes

A "Life-Threatening Condition" is:

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

A "Serious Acute Condition" is

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

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

- upon successful transition of care to a Participating Provider
- upon completion of the course of treatment prior to the 90th day of continuity of care
- upon completion of the 90th day of continuity of care
- if You have met or exceeded the benefit limits under Your plan
- if care is not Medically Necessary
- if care is excluded from your coverage
- if you become ineligible for coverage

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition, up to Molina's Allowed Amount for such services. You may be responsible for any billed amounts that exceed Molina's Allowed Amount or the agreed-upon rate for such services. That would be in addition to any in-network Cost Sharing amounts that you owe under this EOC. In addition, any

payment for the amounts that exceed the previously contracted amount will not be applied to Your Deductible or Your Annual Out-of-Pocket Maximum.

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. For Spanish, select option 1. TTY users may dial 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.

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

Appointment Type For PCPs	When You should get the appointment
Emergency Care	Available 24 hours / 7 days
Urgent care	Within 48 hours of the appointment request
Preventive Care – Non-urgent	Within 30 calendar days of request
Routine or non-urgent care appointments	Within 10 calendar days of request
After-Hours Care	Available 24 hours / 7 days
Office Waiting Time	Should not exceed 30 minutes

PRIOR AUTHORIZATION

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

You do not need Prior Authorization for the following services:

- Emergency Services
- Family planning services
- Habilitative services
- Hospice inpatient care (notification only, Prior Authorization is not required)
- Human Immunodeficiency Virus (HIV) testing and counseling
- Manipulative treatment services, including chiropractic services
- The following outpatient mental health services:
    - Individual and group mental health evaluation and treatment
    - Evaluation of Mental Disorders
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- Office-based procedures
- The following outpatient substance abuse services:
    - Individual and group substance abuse counseling
    - Outpatient medical treatment for withdrawal symptoms
    - Individual substance abuse evaluation and treatment
    - Group substance abuse treatment,
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- Pregnancy and delivery (notification only, Prior Authorization is not required)
- The following rehabilitative services
    - Cardiac therapy

    - Pulmonary therapy
- Services for sexually transmitted diseases
- Urgent Care services from a Participating Provider

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

All inpatient admissions (except hospice)

- Certain Ambulatory Surgery Center service (ASC)*
- Certain drugs as indicated on the published Drug Formulary*
- Certain Durable Medical Equipment*
- Certain injectable drugs and medications not listed on the Molina Drug Formulary*
- Mental Health Services
    - Day treatment
    - Electroconvulsive Therapy (ECT)
    - Mental health inpatient
    - Neuropsychological and psychological testing
    - Partial hospitalization
    - Behavioral health treatment for PDD/autism
- Certain outpatient hospital service*
- Colonoscopy for Members under age 50
- Cosmetic, plastic, and reconstructive procedures
- Custom orthotics, prosthetics, and braces. Examples are:
    - Any kind of wheelchairs (manual or electric)
    - Internally implanted hearing device
    - Scooters
    - Shoes or shoe supports
    - Special braces
- Drug quantities that exceed the day-supply limit
- Experimental or Investigational procedures
- Formulary Specialty (Oral and Injectable) drugs
- Home healthcare and home infusion therapy (after 7 visits for home settings)
    - Hyperbaric therapy
- Imaging and special tests. Examples are:
    - CT (Computed Tomography)
    - MRI (Magnetic Resonance Imaging)
    - MRA (Magnetic Resonance Angiogram)
    - PET (Positron Emission Tomography) scan
- Low vision follow-up care
- Medically Necessary genetic testing
- Occupational Therapy (after initial evaluation and 12 visits/year for outpatient and home settings)
- Out-of-network Urgent Care services
- Pain management services and procedures
- Physical Therapy (after initial evaluation and 12 visits/year for outpatient and home settings)
- Radiation therapy and radio surgery
- Speech Therapy (after 7 visits for outpatient and home settings)
- Services rendered by a Non-Participating Provider, including Urgent Care Services
- Substance Abuse Services:
    - Inpatient services
    - Day Treatment
    - Detoxification Services
    - Partial hospitalization

- Transplant evaluation and related services including Solid Organ and Bone Marrow (Cornea transplant does not require Prior Authorization)
- Non-Emergency Air Ambulance
- Any other services listed as requiring Prior Authorization in this COC

Molina Healthcare might deny a request for a Prior Authorization. You may appeal that decision as described below. If You and Your Participating Provider decide to proceed with service that has been denied agreement, You may have to pay the cost of those services.

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

Approvals are given based on Medical Necessity. We are here to help you. If You have questions about how a certain service is approved, call Us. The number is 1 (888) 858-3973. TTY users may dial 711.

We can explain to You how that type of decision is made. We will send You a copy of the approval process if You request it.

You may call Molina Healthcare at1 (888) 858-3973 to request Prior Authorization. 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 and requests when the Member is an inpatient are processed within 72 hours. This is 72 hours from when we get the information we need and ask for. We need this information to make the decision. We will deny a Prior Authorization if information We request is not provided to Us. The time required may be shorter under Section 2719 of the Federal Public Health Services Act and subsequent rules and regulations. In the case of a request for preauthorization of post-stabilization treatment or a request for preauthorization involving life-threatening condition Molina will process the request within the time appropriate to the circumstances and the condition of the enrollee, up to one hour but in no case shall approval or denial exceed one hour from the time of the request Molina Healthcare processes requests for urgent specialty services immediately by telephone.

If a service request is not Medically Necessary it may be denied. If it is not a Covered Service it 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 in the section "Procedure" agreement.

Standing Approvals
You may have a condition or disease that requires special medical care over a long period of time. You may need a standing approval.
Your condition or disease may be life threatening. It may worsen. It could cause disability. If this is true You may need a standing approval to a specialist physician. You may need one for a specialty care center. They have the expertise to treat Your condition.

To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina's doctors and specialist physicians to be sure Your treatment plan meets Your medical needs. If You have trouble getting a standing approval, call Us. The number is toll-free at 1 (888) 858-3973. TTY users may dial 711.

If You feel Your needs have not been met please see Molina's grievance process. These instructions are in the "Complaints and Appeals" section. Call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-3973. TTY users may dial 711.

Referrals

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

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

You will need a Referral from Your PCP to see a Specialist Physician; however, You can see an OB/GYN without a Referral.

Second Opinions
You or Your PCP may want a second doctor to review Your condition. This can be a PCP or a specialist physician. This doctor looks at Your medical record. The doctor may see You at their office. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Participating Provider Directory on Our website. You can find a Participating Provider for a second opinion. The website is **MolinaMarketplace.com** and click Find a Provider.

Here are some 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 and Your health has not improved.
- You are not sure if 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.
- There may be other reasons. Call Us if You have questions.

EMERGENCY SERVICES AND URGENT CARE SERVICES

What is an Emergency?
Emergency Services are services needed to evaluate, stabilize or treat an **Emergency Medical Condition.** An Emergency Condition includes:

- A medical condition with acute and severe symptoms. This includes severe pain.
- A psychiatric condition with acute and severe symptoms
- Active labor.

If medical attention is not received right away, an Emergency could result in:

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

Emergency Care also includes Emergency contraceptive drug therapy.

HOW DO I GET EMERGENCY CARE?

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

If You think You have an Emergency:

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

When You go for Emergency health care services, bring Your Molina Member ID card.

If You are not sure if You need Emergency care but You need medical help, call Your PCP. Or call Our 24-Hour Nurse Advice Line toll-free.

- English - 1 (888) 275-8750 (For Spanish, select option 1)

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. TTY users may dial 711.

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

If You are away from Molina's Service Area need Emergency Care?
Go to the nearest emergency room for care.

Please contact Molina within 24 hours or as soon as You can. Call toll-free at 1 (888) 858-3973. TTY users may dial 711. When You are away from Molina's Service Area only Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?
Urgent Care Services are available when provided by a Participating Provider. 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's 24-Hour Nurse Advice Line. The number is toll-free.

- English 1 (888) 275-8750 (For Spanish, please select option 1)

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

If You are within Molina's Service Area You can ask Your PCP what urgent care center to use. It is best to find out the name of the urgent care center ahead of time. Ask Your doctor for the name of the urgent care center and the name of the hospital that You are to use.

If You are outside of Molina's Service Area You may go to the nearest emergency room. Out-of-area urgent care centers are covered only with Prior Authorization.

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Please be aware that if You go to a Non-Participating Provider You will be responsible for charges.

You have the right to interpreter services at no cost. To help in getting after hours care call toll-free at 1 (888) 858-3973.

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

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

1) Molina's usual and customary rate for such services,
2) Molina's median contracted rate for such services, or
3) 100% of the Medicare rate for such services.

Because Non-Participating Providers are not in Molina's contracted provider network, they may balance-bill You for the difference between Our Allowed Amount, described above, and the rate that they charge. You may be responsible for provider charges that exceed the Allowed Amount covered under this benefit for Emergency Services rendered by a Non-Participating Provider.

COMPLEX CASE MANAGEMENT

What if I have a difficult health problem?
Living with health problems can be hard. Molina has a program that can help. The Complex Case Management program is for Members with difficult health problems. It is for those who need extra help with their health care needs.

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems. The nurse can teach You how to manage them. The nurse may also work with Your family or caregiver to make sure You get the care You need. The nurse also works with Your doctor. There are several ways You can be referred for this program. There are 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, call toll-free at 1 (888) 858-3973. TTY users may dial 711.

PREGNANCY

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

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

- Licensed Obstetrician-gynecologists (OB/GYNs)
- Certified Nurse Practitioner (trained in women's health)

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits, You must pick an OB/GYN or Certified Nurse Practitioner who is a Participating Provider.

If You need help choosing an OB/GYN, call Us. If You have any questions, call Molina toll-free at 1 (888) 858-3973. We will be happy to help You.

ACCESS TO CARE FOR MEMBERS WITH DISABILITIES

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

Physical Access
Molina 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. TTY users may dial 711. A Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Let us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. Call Molina's Customer Support Center through the National Telecommunication 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 Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement and other materials, please call Molina 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's Customer Support Center.

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

COVERED SERVICES

Molina covers the services described in the section titled "What is Covered Under My Plan?" below. These services are 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
- Except for preventive care and 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, except where specifically noted to the contrary in this EOC – e.g., in the case of an Emergency, You may receive covered services from outside providers.

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. Schedule of Benefits at the beginning of this EOC.

Important Note: Cost Sharing under Your Plan towards Essential Health Benefits may be reduced or eliminated if You are an eligible Member.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits The Affordable Care Act requires preventive services. They will be provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina of Utah, Inc. Schedule of Benefits at the beginning of this EOC. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members.

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

You should review the Molina Healthcare of Utah, Inc. Schedule of Benefits carefully. You need to understand what Your cost sharing will be.

Annual Out-of-Pocket Maximum

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

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

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

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

amount.

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

Coinsurance
Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina of Utah, Inc. Schedule of Benefits. Some Covered Services do not have Coinsurance They 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 of Utah, Inc. Schedule of Benefits. Some Covered Services do not have a Copayment. They 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. Schedule of Benefits. Please refer to the Molina Healthcare of Utah, Inc. Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible when provided by a Participating Provider.

When Molina covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. 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:

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

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

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

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

- If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this EOC, You pay the Cost Sharing in effect on Your admission date. 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 Agreement You pay the Cost Sharing in effect on the date You receive the Covered Services. Also, if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.
- For items ordered in advance, You pay the Cost Sharing in effect on the order date. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order. They must receive all of the information they need to fill the prescription before they process the order.

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. This payment may cover only portions of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due.

The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this Agreement. However, You are responsible for paying charges for any health care services or treatment which are:

- not Covered Services under this Agreement, or
- provided by a Non-Participating Provider, except that Molina will cover services from a Non-Participating Provider:
- for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services,"
- for out-of-area Urgent Care Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services," and
- for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

How Your Coverage Satisfies the Affordable Care Act

Your Covered Services include Essential Health Benefits as required 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 Exchange and pediatric vision services.

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules tell Molina how to administer certain benefits and Cost Sharing 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 Out of Pocket 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. Tax credits may 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 will work with the Marketplace Exchange in helping You.

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

What is Covered Under My Plan?
This section tells You what medical services Molina covers These are called Your Covered Services.

Except for preventive care and services, for a service to be covered **it must be Medically Necessary**.

You have the right to appeal if a service is denied. These instructions are in the "Complaints and Appeals" section.

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Turn to Services for information. Molina also may cover routine medical costs for Members in Approved Clinical Trials.

Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization *before* seeking treatment for such services. To read more about Prior Authorization and a complete list of Covered Services, which require Prior Authorization, turn to "What is a Prior Authorization?" Prior Authorization does not apply to treatment of Emergency Conditions or for Urgent Care Services rendered in an Emergency room or at a Participating Provider Urgent Care facility..

OUTPATIENT PROFESSIONAL SERVICES

Preventive Care and Services

Preventive Services and the Affordable Care Act
Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services. Please consult with Your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for the following when provided by a Participating Provider:

- Those evidenced-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Those immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) Bright Future guidelines as set forth by the American Academy of Pediatricians; and

- With respect to women, those evidence-informed preventive care, screening, test, and supplies provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Scheduled prenatal care exams and first postpartum follow-up consultation exam.

Preventive services are listed on the following webpage:
www.healthcare.gov/center/regulations/prevention.html

All preventive care must be furnished by a Participating Provider to be covered under this Agreement. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

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

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the Affordable Care Act and applicable Utah law. These coverage limitations also are applicable to the below listed preventive care benefits. To help You understand and access Your benefits, preventive services for adults and children that are covered under this Agreement are listed below.

Preventive Services for Children and Adolescents
The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider. Please consult with your PCP to determine whether a specific service is preventive or diagnostic.

- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children 18-24 months
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Behavioral health assessment for children
- Cervical dysplasia screening: sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Early and Periodic Screening, 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.These include those with special health care needs.)
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management

- Hearing screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*
- Iron supplementation in children when prescribed by a Participating Provider
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 10 to 24)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

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

Preventive Services for Adults and Seniors
The following outpatient preventive care services are covered and recommended for all adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider. Please consult with your PCP to determine whether a specific service is preventive or diagnostic.

- Abdominal aortic aneurysm screening: for male former smokers age 65-75
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA counseling about breast cancer preventive medication
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies counseling
- Cancer screening

- Cholesterol check
- Chlamydial infection screening: women
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk.)
- Depression screening: adults
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Dietary evaluation and nutritional counseling
- Exercise of physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention
- Osteoporosis screening for women (based on Your age)
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)

- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 10 to 24)
- Statin preventive medication: adults age 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Screening for tobacco use; and
    - For those who use tobacco products, at least two quit attempts per year of which each attempt includes:
        - Four tobacco-cessation counseling sessions of at least ten minutes each, in the following settings:
            - telephone counseling;
            - group counseling; and
            - individual counseling; and
- Tuberculosis (TB) screening
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

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

PHYSICIAN SERVICES
We cover the following outpatient physician services:

- Prevention, diagnosis, and treatment of illness or injury
- Office visits (including pre- and post-natal visits)
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Routine pediatric and adult health exams
- Specialist Physician for example, a heart doctor or cancer doctor) consultations
- Injections, allergy tests and treatments Physician and other Practitioner care in or out of the hospital
- Medically Necessary neurodevelopmental therapy, consisting of physical, occupational, speech therapy, and aural therapy to restore or improve function based on developmental delay, and for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service.
- 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, and may select an OB/GYN as Your PCP.
- 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 a certified nurse midwife and Other Practitioners; and related laboratory services.
- Medically Necessary at home care

- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP. Female Dependents age 13 and older have direct access to obstetrical and gynecological care.
- Diagnosis and medically indicated treatments for physical conditions causing infertility (Benefit covers only testing, diagnosis, and corrective procedure, subject to exclusions in the "Exclusions" section.)
- Osteoporosis services for women (including treatment and appropriate management when such service are determined to be Medically Necessary by the women's PCP, in consultation with Molina)

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

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

OUTPATIENT AUTISM SPECTRUM DISORDER SERVICES
We cover treatment and services to Members at least two years old, but younger than 10 years old for all generally recognized services prescribed in relation to autism spectrum disorder by the Member's PCP in the treatment plan recommended by that physician. These services include, but are not limited to:

- behavioral health treatment
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

The services must be provided by a Participating Provider or board certified behavior analyst or person licensed under Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, whose scope of practice includes mental health services. Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year. All Covered Services are subject to the Cost Sharing requirements for Outpatient Professional Services.

After the Member reaches age ten "OUTPATIENT AUTISM SPECTRUM DISORDER SERVICES" are no longer available, all other benefits under this Agreement will be available to the Member. All provisions of this Agreement will apply including, but not limited to, defined terms, limitations and exclusions, Prior Authorization and any applicable benefit maximums.

Outpatient Mental/Behavioral Health Services
We cover the following outpatient mental health service when provided by Participating Providers who are physicians or Other Practitioners acting within the scope of their license and qualified to treat mental illness:

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

We cover outpatient mental and behavioral health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We cover mental health services for gender dysphoria. 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/Chemical Dependency Services
We cover the following outpatient care for treatment of substance abuse/chemical dependency:

- Day treatment programs
- Intensive outpatient programs
- Individual, family and group substance abuse/chemical dependency counseling
- Medical treatment for withdrawal symptoms
- Individual substance abuse evaluation and treatment
- Group substance abuse treatment
- We cover substance abuse/chemical dependency under this agreement (evaluation and treatment).
- Group chemical dependency treatment
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations
- Acupuncture treatment services

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

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

Dental Services for Radiation Treatment
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer and other neoplastic diseases in Your head or neck. You must receive services from a Participating Provider physician.

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

- You are under age 7, or You are physically or developmentally disabled, or Your health is compromised
- The dental procedure must be provided in a hospital or outpatient surgery center because of clinical status or existing medical condition
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other services related to the dental procedure, such as the dentist's services, unless included in this section. For Dental Anesthesia services, Coinsurance Cost Sharing will apply, for either Outpatient Hospital/Facility or Inpatient Hospital/Facility settings.

Dental Services for Injury (trauma)
We cover emergency dental services for injury to natural teeth, including oral surgery due to injury and trauma.

Dental and Orthodontic Services for Cleft Palate
We cover some dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services. They must meet all of the following requirements:

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

Services to Treat Temporomandibular Joint Syndrome ("TMJ")
We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ")

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

For Covered Services related to dental or orthodontic care in the above sections, You will pay the Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, see "Inpatient Hospital /Facility Services" in the Molina Healthcare of Utah, Inc. Schedule of Benefits for the Cost Sharing that applies for hospital inpatient care.

DIABETES SERVICES

We cover the following diabetes-related services:
- Diabetic eye examinations (dilated retinal examinations)
- Routine foot care for Members with diabetes

VISON SERVICES

We cover the following vision services for all Members

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

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

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

- Routine vision screening and eye exam, including dilation as professionally indicated, and with refraction, every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of frames. Participating Providers will show the limited selection of frames available to You under this product. Frames that are not within the limited selection of frames under this product are not covered.
- Prescription Lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Prescription Contact Lenses: limited to one pair every 12 months, in lieu of prescription lenses and frames; includes evaluation, fitting and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:
    - Aniridia
    - Aniseikonia
    - Anisometropia
    - Aphakia
    - Corneal disorders
    - Irregular astigmatism
    - Keratoconus
    - Pathological myopia
    - Post-traumatic disorders
- Low vision optical devices are covered including low vision services training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorization is obtained. With Prior Authorization, coverage includes:
    - One comprehensive low vision evaluation every 5 years;
    - High-power spectacles, magnifiers, and telescopes as Medically Necessary; and
    - Follow-up care – four visits in any five-year period.

Laser corrective surgery is not covered.

FAMILY PLANNING
We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. You can do this without having to get Prior Authorization from Molina. (Molina 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
- Health management and counseling to help You 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
- Women’s contraceptives methods approved by the Federal Food and Drug Administration

- Follow-up care for any problems You may have using birth control methods issued by the family planning providers, including insertion and extraction Women's contraceptives methods approved by the Federal Food and Drug Administration.
- Emergency birth control 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

Family Planning services, including all methods of birth control, are provided at No Cost Share to the Member.

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

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 Prior Authorization is required.

Office Visit and Outpatient Surgery Cost Sharing will apply.

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

Phenylketonuria (PKU) and other Inborn Errors of Metabolism
We cover testing and treatment of phenylketonuria (PKU). We also cover other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult 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 Participating Provider.

"**Special food product**" is a food product that is prescribed by a Participating Provider for treatment of PKU. It may also be prescribed for other inborn errors of metabolism. It is used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.
(Prescription Drug Cost Sharing will apply)

Elemental Formula for eosinophilic gastrointestinal associated disorder
We cover Medically Necessary elemental formula, regardless of delivery method, when associated to eosinophilic gastrointestinal associated disorder. This benefit must be order and supervised by a Participating Provider, outpatient professional services Cost Sharing applies.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient Surgery
We cover outpatient surgery services provided by Participating Providers. Services must be 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 some outpatient procedures other than surgery provided by Participating Providers. We cover these procedures if a licensed staff member monitors Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Separate Cost Sharing may apply for professional services and facility services.

Specialized Imaging and Scanning Services
We cover Medically Necessary specialized scanning services. They include CT Scan, PET Scan, cardiac imaging, ultrasound imaging and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services. Prior Authorization is required. Molina will help you select an appropriate facility.

Radiology Services (X-Rays)
We cover Medically Necessary x-ray and radiology services, other than specialized scanning services. Separate Cost Sharing may apply for professional services and Health Care Facility services. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

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

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

- Laboratory services, supplies and test, including Medically Necessary genetic testing
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood, blood products, and blood storage, including the services and supplies of a blood bank. Autologous (self) blood storage is not a Covered service.
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high risk pregnancy
- Alpha-Fetoprotein (AFP) screening

Mental/Behavioral Health
Outpatient Intensive Psychiatric Treatment program
We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility; 24-hour-a-day monitoring must be provided by clinical staff for stabilization of an acute psychiatric crisis; including medication as part of a treatment plan.
- Psychiatric observation for an acute psychiatric crisis
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency or in-network Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency or in-network Urgent Care Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated.

Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

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

Medical/Surgical Services
We cover the following inpatient services in a Participating Provider hospital. These services are generally and customarily provided by acute care general hospitals inside Our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- 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)
- Biologicals, fluids and chemotherapy
- 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 (not less than 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer)

- Mastectomy-related services, including Covered Services under the "Reconstructive Surgery" section and under the "Prosthetic and Orthotic Devices" section
- Blood, blood products, and their administration
- Physical, occupational, speech therapy, and aural therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

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

Maternity Care
Molina covers medical, surgical and hospital care during the term of pregnancy. This includes prenatal, intrapartum and perinatal care, upon delivery for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

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

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays require that You or Your provider notifies Molina. Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Molina Healthcare of Utah, Inc. Schedule of Benefits for the Cost Sharing that will apply to these services.
- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Participating Provider. It must be based on Medical Necessity and in consultation with the mother. If the hospitalization period is shortened, then at least 3 home care visits will be provided. You and Your physician may agree that 1 or 2 visits are sufficient. Home care includes parent education, assistance and training in breast and bottle-feeding, and the administering of any appropriate clinical tests. (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).
- Nursery services and supplies for newborns, including newly adopted children;
- If You are a medically high-risk pregnant woman about to deliver a baby, we cover transportation, including air transport, to the nearest appropriate Health Care Facility when necessary to protect the life of the infant or mother.

Mental/Behavioral Health
Inpatient Psychiatric Hospitalization

We cover inpatient psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians and other Participating Providers who are licensed health care professionals acting within the scope of their license. Involuntary court-ordered inpatient mental health and behavioral health admissions do not require Prior Authorization. Involuntary court-ordered inpatient mental health and behavioral services beyond 72 hours, will be covered only if deemed Medically Necessary by Molina Healthcare's Medical director or designee and available in a Molina participating hospital under the following conditions. We cover inpatient mental and behavioral health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**Mental Disorders**" include 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,
- bulimia nervosa

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY
INPATIENT DETOXIFICATION
We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of withdrawal symptoms. This includes:

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

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

Skilled Nursing Facility
We cover skilled nursing facility (SNF) services when Medically Necessary. Covered SNF services include:

- Room and board
- Physician, nursing and Other Practitioner services, including licensed behavioral health providers
- Medications
- Injections

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

The SNF benefit is limited to 30 days per calendar year. Services must be billed by a Skilled Nursing Facility Participating Provider.

Coverage at a long-term care facility following hospitalization
We cover up to 60 days of Medically Necessary care at a Long-Term Care Facility following hospitalization if You resided in that Long-Term Care Facility immediately prior to the hospitalization, and all of the following are met:

Your Primary Care Physician determines that Your medical care needs can be met at the requested Facility. The requested Facility has all applicable licenses and certifications, and is not under a stop placement order that prevents Your readmission.

The requested Facility agrees to accept payment for Covered Services at the rate We pay to similar Facilities that are Participating Providers

The requested Facility agrees to abide by the standards, terms, and conditions We require for similar Facilities that are Participating Providers for (i) utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting

A "Long-Term Care Facility" or "Facility" for the purpose of this benefit is a nursing facility licensed under Chapter 18.51 of the Revised Code of Utah, a continuing care retirement community defined under Section 70.38.025 of the Revised Code of Utah, or an assisted living facility licensed under Chapter 18.20 of the Revised Code of Utah.

You, or Your authorized representative, must obtain Prior Authorization for these services.
Inpatient Hospital/Facility Services Coinsurance Cost Sharing will apply.

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

- Home hospice services
- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services for outpatient care
- Physician services
- Drugs
- Medical supplies and appliances
- Respite care for up to fourteen (14) days per lifetime. 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. We provide these therapies 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. Terminal illness means a life expectancy of 12 months or less. They can choose hospice care instead of the traditional services covered by this product. Please contact Molina for further information.

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

Approved Clinical Trials
We cover routine patient care costs for qualifying Members. Qualifying Members are those 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 agreement
- 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 doctor who is a Participating Provider
- Received Prior Authorization or approval from Molina

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. These trials are conducted in relation to the prevention, detection, or treatment of cancer. They may also be conducted for other life-threatening disease or condition. In addition:

- 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
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. Contact Molina 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. Such costs are associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this Agreement based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered. They will not be covered if the approved clinical trial is for the investigation of that drug. They will also not be covered for medication that 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. Schedule of Benefits.

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

- The investigational item, device or service itself
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- Any service that does not fit 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. These abnormal structures may be caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. If a Participating Provider physician decides that it is necessary to improve function, or create a normal appearance, to the extent possible, the services will be covered.
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast. Molina will also cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Molina covers 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. Schedule of Benefits.

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

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

Transplant Services
We cover transplants of organs, tissue, or bone marrow or artificial organ transplants based on Molina's medical guidelines and manufacturer's recommendations at participating facilities. Molina must authorize services for care to a transplant facility, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

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

- If either the physician or the authorized Health Care Facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that decision is made.
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor. Molina will provide services for 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. This 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 toll-free at 1 (888) 858-3973. TTY users may dial 711.

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 of Utah, Inc. Schedule of Benefit. Limited transplant-related travel services will be covered subject to Prior Authorization. Guidelines for transplant-related travel services are available by calling toll-free at 1 (888) 858-3973. If You are deaf or hard of hearing, dial 711 for the National Telecommunication Service. Molina provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with Our guidelines for donor services at no charge.

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications, subject to applicable Cost Sharing under the following conditions:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Healthcare Drug Formulary. Drugs approved by Molina's Pharmacy Department are also covered.
- 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. They must be ordered by a Participating Provider in connection with a Covered Service. The prescription drugs are obtained through a pharmacy that is in the Molina 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.

Also, subject to applicable Cost Sharing, and as prescribed by a Participating Provider:

- We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications.
- We cover for the human papillomavirus vaccine for female Members who are nine to fourteen years of age.

We cover prescription drugs and medications at a plan contracted retail pharmacy unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy.

Please note, cost sharing for any prescription drugs obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer will not apply toward any Deductible, or the Annual Out-of-Pocket maximum under Your Plan.

We cover:

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

Such prescription drugs must be obtained through Molina Healthcare's contracted pharmacies within Utah.

Prescription drugs are covered outside of the state of Utah (out of area) for Emergency services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 858-3973. TTY users may dial 711.
If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 858-3973. You may view a list of pharmacies on Molina Healthcare's website, **MolinaMarketplace.com**.

Molina Healthcare Drug Formulary (List of Drugs)
Molina Healthcare has a list of drugs that it will cover. The list is called the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. The group meets every three months to talk about the drugs that are in the formulary. They review new drugs and changes in health care. They try to find the most effective drugs for different conditions. Drugs are added or removed from the Drug Formulary for different reasons. This could be:

- Changes in medical practice
- Medical technology
- When new drugs come on the market.

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

Formulary brand name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina and Our pharmacy benefit manager.

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is **MolinaMarketplace.com**. You may call Molina Healthcare and ask about a drug. Call toll-free at 1 (888) 858-3973. TTY users may dial 711.

You can also ask Us to mail You a copy of the Drug Formulary. A drug listed on the Drug Formulary does not guarantee that Your doctor will prescribe it for You.

Cost Sharing for Prescription Drugs and Medications

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

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

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

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

Tier-2 Preferred Generic and Brand Name Drugs

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

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

Tier-3 Non-Preferred Brand Name Drugs

Formulary drugs in this tier include non-preferred brand name drugs. Specialty drugs are not included in this tier.
Non-preferred brand name drugs are those drugs listed in the Molina Drug Formulary that are designated as "Tier-3" due to lesser clinical effectiveness and cost differences. Generally, there are preferred and often less costly therapeutic alternatives at a lower tier.

Tier-4 Generic and Brand Name Specialty Drugs

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

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

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies; or
- A biosimilar, a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

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

Tier-5 Preventive Drugs

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

Access to Drugs Which are Not Covered
Molina has a process to allow You to request clinically appropriate drugs that are not covered under Your Agreement

Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of

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

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

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

For substitution of a Formulary Generic Drug with a Non-Formulary Brand Drug, You may purchase the brand name drug at the following Cost Sharing:

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

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

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

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

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

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

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

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

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

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

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

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

Stop-Smoking Drugs
Stop-Smoking drugs are prescription drugs within the Molina Healthcare Drug Formulary that we cover to help You stop smoking. You can learn more about Your choices by calling Molina Healthcare's Health Management Level 1 Programs Department toll-free at 1 (866) 472-9483, between 7:00 a.m. and 7:00 p.m. MT, 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, both prescription and over-the-counter medications, at no cost to you. You will also be given a phone number that You can call anytime You need help.

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

You may request mail order service in the following ways:

- You can order online. Visit **MolinaMarketplace.com** and select the mail order option. Then follow the prompts.
- You can call the FastStart® toll-free number at 1-800-875-0867. Provide Your Molina Member number (found on Your ID card), Your prescription name(s), Your doctor's name and phone number, and Your mailing address.
- You can mail a mail order request form. Visit **MolinaMarketplace.com** and select the mail order form option.

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

Diabetes Supplies
Diabetes supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, glucagon emergency kits, blood glucose test strips and urine test strips are covered supplies. Select pen delivery systems for the administration of insulin are also covered.

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

ANCILLARY SERVICES

Durable Medical Equipment

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

Covered DME includes (but is not limited to):

- Oxygen and oxygen equipment
- Apnea monitors
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy supplies (limited to pouches, face plates, belts, irrigation catheters, and skin barriers)

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

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

Prosthetic and Orthotic Devices
We cover:

- 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
- Any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities.

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, Osseo integrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Us. For internally implanted devices, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the Molina Healthcare of Utah, Inc. Schedule of Benefits to see the Cost Sharing applicable to these devices.

External devices
We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Splints
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Prostheses used to replace a missing part (such as a hand, arm, or leg) that is needed to alleviate or correct illness, injury, or congenital defects, including braces (not orthodontic braces), limited to medically appropriate equipment and subject to Prior Authorization. All services and supplies necessary for the effective use of a prosthetic device, including: formulating its design; fabrication; material and component selection; measurements and fittings; static and dynamic alignments; and instructing the patient in the use of the prosthetic device; and may limit coverage for the purchase, repair, or replacement of a microprocessor component for a prosthetic device per limb, every three years. Repair or replacement of such prostheses is a Covered Service only when Medically Necessary and subject to Prior Authorization.

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

Home Healthcare
We cover these home health care services – i.e., health services provided on a part-time, intermittent basis to an individual confined to his or her home due to physical illness – when such services are Medically Necessary 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
- Up to 30 visits per calendar year (counting all home health visits). Services must be billed by a Home Healthcare Participating Provider agency

You must have Prior Authorization after 7 visits for home settings. 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 (ground and air ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary. These services are covered only when other types of transportation would put your health or safety at risk. Covered emergency medical transportation services will be provided at the Cost Sharing identified within the Schedule of Benefits, up to Molina's Allowed Amount for such services. Please note: You may be responsible for provider charges that exceed Molina's Allowed Amount covered under this benefit for Emergency medical transportation services rendered by a Non-Participating Provider.

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

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 facility or at Health Care Facility

COVERED SERVICES FURNISHED WHILE TRAVELING OUTSIDE THE SERVICE AREA INCLUDING OUTSIDE OF THE UNITED STATES
Your Covered Services include Emergency Services while traveling outside of the Service Area, including travel that takes You outside of the United States. If You need Emergency Care Services while traveling outside the United States, or outside of the Service Area, go to Your nearest 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 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 specific 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.

Circumcision
Circumcision is not a covered benefit.

Cosmetic Services
Any care, treatment or procedure performed primarily for cosmetic purposes is not covered or services that are intended primarily to change or maintain Your appearance. Services are considered cosmetic when they are intended to improve appearance or correct a deformity without restoring physical bodily function. Cosmetic services that are not covered include, but are not limited to:

a. Breast reconstructive surgery except as allowed under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). (See the WHCRA notice in this Benefits Summary for further information and limitations);
b. Any reconstructive surgery, except those made necessary by an accidental injury occurring in the preceding 5 years;
c. Rhinoplasty, except as a result of an accidental injury occurring in the preceding 5 years;
d. Lipectomy, abdominoplasty, repair of diastasis recti and panniculectomy;
e. Hair transplants or other services to treat hair loss.

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 the following, are not covered:

- X-rays
- Appliances
- Implants

- Treatment of malocclusion
- Services provided by dentists or orthodontists
- Dental services following accidental injury to teeth
- Dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment

Dietician
A service of a dietician is not a covered benefit. This exclusion does not apply to Covered Services under hospice care.

Disposable Supplies
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, 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
- Air Conditioners
- Alarm systems
- Allergy free blanket, pillow case, or mattress cover
- Ankle foot orthotic (AFO)
- Arch supports, insoles, heel cushions, etc.
- 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
- 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
- Continuous hypothermia machine
- 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)
- Deionizer, 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
- Lift platform, wheelchair, van or home
- Lift, chair (seat)
- Light box (seasonal)
- 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)
- 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
- TENS units
- Theraband
- Therapy ball, roll, putty
- Thermometer
- Tips, replacement (wheelchair, walker, crutches, etc.)
- Toddler Walkabout
- Toileting Aids
- Tool Kits
- Tracheostomy Speaking Valve
- Traction, Cervical, Extremity, Pelvic
- Traction, Overdoor
- Transcutaneous Electrical Nerve Stimulator (TENS) Unit, including supplies
- Transfer Board
- Trapeze Bars
- Tray, Desk, Drafting Table, Easel, Caddy Tray, Cup Holder, etc. (wheelchair)
- Tricycle, Hip Extensor
- Ultraviolet Cabinet
- Ultraviolet Lamp, handheld
- Upholstery, Reinforcement or Replacement
- Urinals
- Used Equipment
- Uterine Activity Monitor, with pregnancy
- Van, Van Conversion
- Vaporizer, room type

- Ventilator—purchase
- Vibrating Chair
- Vibrators
- Vision Aid or Device
- Walkers and attachments, Basic—purchase
- Walkers and attachments, Basic—rental
- Walkers and attachments, Specialty—purchase
- Walkers and attachments, Specialty—rental
- Waterbed
- Wheelchair Ramp
- Wheelchair, auto carrier
- Wheelchair, backpacks, caddy, carrier, baskets, etc.
- Wheelchair, heel, toe Loops replacement
- Wheelchair, Spoke Protectors
- Wheelchair, Stand-Up
- Wheelchair, Tune-up
- Wheelchair, Utility Tray
- Wheel mobile
- Whirlpool Bath Equipment
- Whirlpool Pumps
- White Cane
- Wig, Hair Piece
- Work Table
- Wrist Alarm

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. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Utah, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

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.

Gene Therapy
Molina does not cover gene therapy.

Hair Loss or Growth Treatment
We do not cover items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

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

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

Intermediate Care facility (ICF)
A health related facility designed to provide custodial care for individuals unable to care for themselves because of mental or physical infirmity, but without the degree of care provided by a hospital or skilled nursing facility.

Items and Services That are Not Health Care Items and Services
Molina Healthcare does not cover services that are not health care services. Examples of these types of services are:

- 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
Molina does not cover items and services (such as eye surgery or contact lenses to reshape the eye) for 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.

Male Contraceptives
Condoms are not covered

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

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed for the treatment of Phenylketonuria or other inborn errors of metabolism involving amino acids, in accordance with the" Phenylketonuria (PKU)" section of this EOC.

Private Duty Nursing Services
We do not cover private duty nursing services.

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 Disorder Services" section.

Routine Foot Care Items and Services
Routine foot care items and services which are not Medically Necessary (for example, Medically Necessary for the treatment of diabetes)

Secondary Conditions or Complications due to any non- covered benefit
Medical services, procedures, supplies or drugs used to treat secondary conditions or complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such complications include, but are not limited to:

a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof;
b. Complications as a result of a cosmetic surgery or procedure, except in cases of reconstructive surgery:
    1. When the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved party; or
    2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect; or
c. Complications relating to services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for purposes other than its FDA-Approved purpose.

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.

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

This exclusion does not apply to services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan" section.

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

Services Performed by Unlicensed People
We do not cover services performed by people who do not require licenses or certificates by the state to provide health care services, except as otherwise provided in this agreement.

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 would otherwise cover to treat complications of the non-Covered Service. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service. For example, if You have a non-covered bariatric surgery or cosmetic surgery, Molina would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina would cover any services that Molina would otherwise cover to treat that complication.

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

Sexual Dysfunction Drugs
Coverage of Sexual dysfunction drugs including erectile dysfunction drugs unless required by state law.

Sleep Study
Sleep Studies are not covered.

Spinal Cord Stimulator
Spinal cord stimulator (SCS), also known as a dorsal column stimulator, is not a covered benefit.

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.

Travel and Lodging Expenses
Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from Our Customer Support Center by calling toll-free at 1 (888) 858-3973. TTY users may dial 711.

Services Provided Outside the United States (or Service Area)
Any services and supplies provided to a Member outside the United States if the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, Specialist Physician care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area unless they are Emergency Services furnished to a Member while traveling.

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

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

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

Molina Healthcare shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries 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.

Varicose veins
Varicose vein treatment and surgery are not covered.

Other Exclusions
The following services are not covered:

- Breast reduction;
- Blepharoplasty or other eyelid surgery;
- Sclerotherapy;
- Microphlebectomy (Stab phlebectomy);
- Treatment programs for enuresis or encopresis are not covered.
- Services or items primarily for convenience or other non-therapeutic purposes, such as: guest trays, personal hygiene items, home health aide and home nursing, are not covered
- Services provided in a nursing home, rest home or a transitional living facility, community reintegration program, or vocational rehabilitation services to re-train self-care or activities of daily living (ADLs), including occupational therapy for activities of daily living (ADLs), academic learning, vocational or life skills or developmental delays, are not covered.
- Recreational therapy in any setting is not covered.
- Biological serum, blood and blood plasma are not covered through the pharmacy card. Charges related to storing blood for future use are not covered.
- Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by Molina, or when the transplant for the Molina Member is not eligible, are not covered.
- Outpatient nutritional analysis or counseling is not covered, except in conjunction with anorexia/bulimia, diabetes education, and Affordable Care Act Preventive Services.
- Custodial care and/or maintenance therapy is not covered.
- Take home medications are not covered.
- Obesity surgery, such as gastric bypass, lap-band surgery, etc., including any present and future complications, are not covered
- Services that are dental in origin, including care and treatment of teeth and gums, orthodontia, periodontia, endodontia or prosthodontia are not covered.
- Sperm banking system, storage, treatment or other such services are not covered.

- Artificial prosthetics, such as eyes, when made necessary by loss from an injury or illness, must be preauthorized. If approved, the maximum prosthetic benefit is once in five years, per site.
- Laser assisted uvulopalotoplasty (LAUP) or any other surgery solely for snoring is not covered in accordance with state law.
- Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
- Treatment for sexual dysfunction is not covered.
- Physical, occupational, and speech therapy visits are only payable up to combined plan limits. Please refer to the Schedule of Benefits for limit information.
- Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis, when billed by providers of the same specialty, is eligible for payment.
- Charges for physical examinations performed in connection with hearing aids are not covered.
- Emergency care for Life-threatening injury or illness caused by attempted suicide or anorexia/bulimia is covered as a medical benefit. Once the patient's health is stabilized, further benefits will be payable at the inpatient mental health benefit level.
- Charges for office visits in connection with repetitive injections (e.g., allergy or hormone injections) are not covered.
- Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services is not covered.
- Acupuncture treatment is not covered.
- Hypnotherapy and biofeedback services are not covered.
- Testing and treatment therapies for developmental delay or child development programs are not covered.
- Cardiac rehabilitation, Phases 3 and 4 are not covered.
- Pulmonary rehabilitation, Phase 3 is not covered.
- Fitness programs are not covered.
- Childbirth education classes are not covered.
- The practice of using numerous procedure codes to identify procedures that normally are covered by a single code, known as "unbundling" is not covered.
- Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations are not covered.
- Inpatient provider visits will be payable only in conjunction with authorized inpatient days.
- Hospital leave of absence charges are not covered.
- Service for milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances are not covered.
- Residential treatment programs are not covered.
- Benefits for ground ambulance are payable only for medical emergencies and only to the nearest facility where proper care is available. Benefits for air ambulance are payable only for Life-threatening emergencies when you could not be safely transported by ground ambulance and only to the nearest facility where proper medical care is available.
- Ambulance services for the convenience of the patient or family are not covered.
- Skilled nursing visits may be approved up to a limit of 30 visits per plan year.
- Hospice services may be approved for up to 6 months in a 3 year period.
- Home health aide is not covered.
- Travel or transportation expenses, or escort services to provider's offices or elsewhere are not covered.
- Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by Molina.

- Wheelchairs require Pre-authorization through Medical Case Management and are limited to one in any five-year period.
- Reimbursement for knee braces is limited to one in a three-year period. New or used equipment purchased from non-licensed providers is not covered.
- Used Durable Medical Equipment is not covered.
- Charges for all services received as a result of an industrial claim (on-the job) injury or illness, any portion of which, is payable under Worker's Compensation or employer's liability laws are not covered.
- Charges that you are not, in absence of coverage, legally obligated to pay are not covered.
- Charges for medical care rendered by an immediate family member are not covered. Immediate family members are spouses, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, step-parents, step-children, grandparents, grandchildren, uncles, aunts, nieces and nephews.
- Charges that are not Medically Necessary to treat the condition, as determined by Molina, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury are not covered.
- Overutilization of medical benefits as determined by Molina is not covered.
- Charges for services as a result of an auto-related injury covered under No-fault insurance or that would have been covered if coverage were in effect as required by law, are not covered.
- The following services are not covered when incurred in connection with injury or illness arising from the commission of: a. a felony; b. an assault, riot or breach of peace; c. a Class A misdemeanor; d. any criminal conduct involving the illegal use of firearm or other deadly weapon; e. other illegal acts of violence when the insured is a voluntary participant.
- Amounts paid for the following services will not apply to your out-of-pocket maximum:
    - Penalties for failing to obtain Pre-authorization or to complete Pre-notification;
    - Any service or amount established as ineligible under this policy or considered inappropriate medical care;
    - Charges in excess of Molina's maximum allowable fee or contract limitations.
- Mastectomy for gynecomastia is not covered.
- Rhytidectomy
- Subtalar implants
- Otoplasty
- Additional fees charged because a robotic surgical system was used during surgery.
- Anesthesia limits, i.e., not covered when administered by a primary surgeon (A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.)
- Chelation therapy
- Rolfing or massage therapy
- Visits in conjunction with palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease.

WORKERS' COMPENSATION

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

If Molina Healthcare provides benefits 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 annual open enrollment period.

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

The above does not apply in the following circumstances:

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

When Will My Molina Membership End?
(Termination of Covered Services)
The termination date of Your coverage is the first day You are not covered with Molina (for example, if Your termination date is July 1, 2018, Your last minute of coverage was at 11:59 p.m. on June 30, 2018). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina will return to You within 30 days the amount of Premiums paid to Molina 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.

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 1 (801) 538-3077; or electronically at healthappeals.uid@utah.gov.

Your membership with Molina Healthcare will terminate if You:

- **Cancel Your Co**verage 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 Mee**t Eligibility Requirements: You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina or the Marketplace

Exchange. You no longer live Molina's Service Area for this product. The Marketplace Exchange will send You notice of any eligibility determination. Molina will send You notice when it learns You have moved out of the Service Area.

- **For Non-Age-Related loss of Eligibility,** Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.
  - For a Dependent Child Reaching the Limiting Age of 26, Coverage under this agreement, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the calendar year in which the Dependent Child reaches the limiting age of 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)."
  - For a Non-Dependent Member with Child-Only Coverage Reaching the Limiting Age, Child-Only Coverage under this agreement, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the month in which the non-Dependent Member reaches the limiting age of 21. When Child-Only Coverage under this agreement terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace Exchange.
- **Request Disenrollment:** You decide to end Your membership and disenroll from Molina by notifying the Marketplace Exchange. 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 may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.
- **Have Child-Only Coverage**: Child-Only Coverage under this Agreement, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches age 21. When Child-Only Coverage under this agreement terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace Exchange.
- **Change Marketplace Exchange Health Plans:** You decide to change from Molina to another health plan offered through the Marketplace Exchange during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace Exchange's special enrollment procedures, or when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.
- **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. 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 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 ceases to provide or arrange for the provision of Marketplaces for new or existing health care service in the individual market, in which case Molina will provide You with written notice at least 180 days prior to the date the coverage will be discontinued.
- **Withdrawal of Product:** Molina withdraws Your product from the market, in which case Molina will provide You with written notice at least 90 days prior to the date the coverage will be discontinued.
- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina may terminate Your coverage as further described below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. If only certain Covered Services end because a Member attains a certain age, then coverage of those benefits under this agreement will end at 11:59 p.m. on the last day of the month in which the Member has reached the limiting age, without affecting that Member's coverage under the remainder of this agreement. Any Dependent Member who no longer is eligible to remain on the coverage because of termination of marriage or death of the principle Subscriber, shall have the right to continue this agreement without any proof of insurability. Please contact the Molina Customer Support Center at 1 (888) 858-3973. TTY users may dial 711.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

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

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

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

- 15-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit. Molina will process payment for Covered Services received during the 15-day grace period. You will be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period; or
- Three-month grace period to pay the full Premium payment due if You receive advance payment of the premium tax credit. Molina will hold payment for Covered Services received after the first month of the grace period until We receive the delinquent Premiums. If Premiums are not received by the end of the three-month grace period, You will be responsible for payment of the Covered Services received during the second and third months.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe to Molina Healthcare. If You do not pay the full Premium payment by the end of the grace period, this Agreement will be terminated. You will still be responsible for any unpaid Premiums. You owe Molina Healthcare 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.:

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

Reinstatement After Termination for Non-Payment of Premiums
If permitted by the Marketplace, We will allow reinstatement of Your Agreement (without a break in coverage) provided the reinstatement is a correction of an erroneous termination or cancellation action.

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

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

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

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

YOUR RIGHTS AND RESPONSIBILITIES

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

These rights and responsibilities are posted on the Molina Healthcare web site: **MolinaMarketplace.com**.

Your Rights
You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina.
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina'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 or Your care. You can call, fax, e-mail or write to Molina's Customer Support Center.
- Appeal Molina's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina (leave the Molina Healthcare product).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get interpreter services on a 24-hour basis at no cost to help You talk with Your doctor or with us if You prefer to speak a language other than English.
- Get information about Molina, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats 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.
- Free Information on medical necessity criteria due to adverse benefit determinations.
- Get a copy of Molina's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.
- Not to be treated poorly by Molina or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1 (888) 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 card when getting medical care. Do not give Your card to others. Let Molina know about any fraud or wrongdoing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active In Your Healthcare

Plan Ahead

- Schedule Your appointments at a good time for You.
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long.

- Keep a list of questions You want to ask Your doctor.
- Refill Your prescription before You run out of medicine.

Make the Most of Doctor Visits

- Ask Your doctor questions.
- Ask about possible side effects of any medication prescribed.
- Tell Your doctor if You are drinking any teas or taking herbs. 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'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 toll-free at 1 (888) 858-3973. TTY users may dial 711. 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. We have a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

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

What Do I Have to Pay For?
Please refer to the "Molina of Utah, Inc. Schedule of Benefits" at the front of this EOC for Your Cost Sharing responsibilities for Covered Services.

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

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

If Molina Healthcare fails to pay a Molina contracted provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by us. This is not true for non-Participating Providers who are not contracted with Molina Healthcare. Benefits for services provided to Your minor Dependent child may be paid to a third party if:

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

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

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

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

With the exception of any required Cost Sharing amounts (such as a Deductible, Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back. . You must submit Your claim for reimbursement within 12 months from the date you made the payment.

You will need to mail or fax us a copy of the bill from the doctor, Hospital or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on the first page of this 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 contracts with providers in many ways. Some Molina 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 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 Us toll-free at 1 (888) 858-3973. TTY users may dial 711. We are here 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.

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

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

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

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

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

"**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 1 (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" and "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 toll-free at 1 (888) 858-3973. TTY users may dial 711.

COMPLAINTS AND APPEALS

What is a Complaint?
A complaint is any dissatisfaction that You have with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, You may be dissatisfied with the hours of

availability of Your doctor. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the Utah Department of Insurance in the manner described in the Internal Appeals section below.

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) 858-3973. TTY users may dial 711.
- You may also send us Your problem or complaint in writing by mail or filing online at Our website. Our address is:

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

  Or You may contact the Utah Insurance Department Consumer Services:

  Utah Insurance Commissioner
  Suite 3110
  State Office Building
  Salt Lake City UT 84114
  1 (801) 538-3077
  healthappeals.uid@utah.gov

Molina recognizes the fact that You may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. We want to know about Your concerns and any complaints You may have. We will respond to Your complaint no later than 60 days from when We receive it.

APPEALS

Definitions
The capitalized terms used in this appeals section have the following definitions:
"Adverse Benefit Determination" means

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

- Any reduction or termination of a benefit, or any other coverage determination that an admission, availability of care, continued stay, or other health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness; or

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

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

- An Adverse Benefit Determination is also a rescission of coverage as well as any other cancellation or discontinuance of coverage that has a retroactive effect, except when such

cancellation/discontinuance is due to a failure to timely pay required Premiums or contributions toward cost of coverage.

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

- "Authorized Representative": means an individual authorized in writing by You or state law or rule 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

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. Your coverage will remain in effect pending the outcome of Your internal 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 IN-NETWORK 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
1 (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
MolinaMarketplace.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 1 (888) 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's Control
If circumstances beyond the reasonable control of Molina, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina nor any Participating Provider shall have any liability or obligation for delay or failure to provide Covered Services if such delay or failure is the result of any of the circumstances described above.

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

Non-Discrimination

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

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1 (888) 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 registering with the Utah Department of Licensing when You apply for or renew Your Driver's License or by going online at www.donatelifetoday.org to add Your name to the registry.

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

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without Molina's prior written consent (which consent may be refused in Molina's discretion).

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

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

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

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 the address on the first page of this EOC 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. Foreign claims and proof of loss relating to such claims must be translated in U.S. currency prior to being submitted to Molina Healthcare

WELLNESS PROGRAM

Your Agreement includes access to a health activities program. The goal of the program is to encourage You to complete health activities that support Your overall health. The program is voluntary and available at no additional cost to You. The health activities we encourage you to complete, are described below. For more information, please contact Member Services phone number on your ID Card.

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

Annual Wellness Exam
Provides You with the opportunity to obtain either an annual comprehensive physical exam through your Primary Care Provider, or an In-home health assessment exam facilitated through Molina.

HEALTH MANAGEMENT PROGRAMS

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

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

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

You can also enroll in any of the programs above by calling the Molina Healthcare Health Management Department at 1 (866) 891-2320, between 5:00 a.m. and 9:00 p.m., Monday through Friday. You may also call to ask for a booklet to help you manage your diagnosed health condition.

MEMBER ASSESSMENT/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 7:00 a.m. and 7:00 p.m. MT, Monday through Friday. Ask about other services We provide, or request information to be mailed to You.

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

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support. Call toll-free 1 (866) 472-9483 between 7:00 a.m. and 7:00 p.m. MT, Monday through Friday.

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. Fitness programs are not offered. Call toll-free 1 (866) 472-9483 between 7:00 a.m. and 7:00 p.m. MT, Monday through Friday.

YOUR HEALTHCARE QUICK REFERENCE GUIDE

Department/Program	Type of help needed	Number to Call
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 Members with speech or hearing impairment may dial 711 for the National Telecommunication 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 (866) 891-2320 between 5:00 a.m. and 9:00 p.m., Monday through Friday
Member Assessment/Health Education	To request information on wellness, including smoking cessation and weight management.	1 (866) 472-9483 between 7:00 a.m. and 7:00 p.m., Monday through Friday
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, select option 1.
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that We have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	1 (800) 368-1019 TTY for deaf or hard of hearing: 1 (800) 537-7697 FAX: 1 (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 **http://www.Medicare.gov**
Utah Insurance Department, Health Insurance Division, Consumer Services	The Utah Insurance Department is responsible for regulating health care services plans and is available by phone between 8:00 a.m. and 5:00 p.m., Monday through Friday or email at any time. If You have a complaint against Your health plan, You should first call Molina Healthcare toll-free at 1-888-858-3973, and use Molina Healthcare's grievance process before contacting this department.	(801) 538-3077 TTY: (801) 538-3826 http://www.insurance.utah.gov Email: health.uid@utah.gov