2016

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

Molina Marketplace – Silver 150 Plan

Wisconsin

2400 South 102nd Street, West Allis, WI 53227

MolinaHealthcare.com/Marketplace

MOLINA® HEALTHCARE

MOLINA HEALTHCARE OF WISCONSIN, INC.
BENEFITS AND COVERAGE GUIDE

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

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

Except for Emergency Services and out-of-area Urgent Care Services, 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.

Deductible T	**At Participating Providers, You Pay**
Medical Deductible (Applies only to outpatient hospital/facility services and inpatient hospital/facility services)	
Individual	$450
Entire Family of 2 or more Members	$900
Other Deductibles	
Prescription Drug Deductible	
Individual	$0
Entire Family of 2 or more Members	$0
Annual Out of Pocket Maximum*	**At Participating Providers, You Pay**
Individual	$2,250
Entire Family of 2 or more Members	$4,500

* Medically Necessary Emergency Services and Urgent Care Services furnished by a Non-Participating Provider will apply to Your annual OOPM.

Emergency and Urgent Care Services †		**You Pay**
Emergency Services‡	$150	Copayment per visit
Urgent Care Services	$30	Copayment per visit

† Please note: You may be responsible for provider charges that exceed the allowed amount covered under this benefit for emergency/urgent care services rendered by a Non-Participating Provider.

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

Outpatient Professional Services*	At Participating Providers, You Pay	
Office Visits		
Preventive Care (Includes prenatal and postpartum exams)	No Charge	
Primary Care (PCP)	$10	Copayment per visit
Specialty Care	$30	Copayment per visit
Other Practitioner Care	$10	Copayment per visit
Habilitative Services	20%	Coinsurance
Rehabilitative Services	20%	Coinsurance
Manipulative Treatment Services	20%	Coinsurance
Autism Spectrum Disorder Services	$10	Copayment per visit
Mental Health Services	$10	Copayment per visit
Substance Abuse Services	$10	Copayment per visit
Dental Services Related to Accidental Injury	20%	Coinsurance
Family Planning	No Charge	
Pediatric Vision Services (for Members under age 19 only)		
Vision Exam (Screening and exam, limited to 1 exam each calendar year)	No Charge	
Prescription Glasses		
Frames: • Limited to 1 pair of frames every 12 months • Limited to a selection of covered frames	No Charge	
Lenses: • Limited to 1 pair of prescription lenses every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, UV protection	No Charge	
Prescription Contact Lenses In lieu of prescription glasses, limited to 1 pair of standard contact lenses every calendar year. Medically Necessary contact lenses for specified medical conditions require Prior Authorization."	No Charge	
Low Vision Optical Devices and Services (Subject to limitations. Prior Authorization applies.)	No Charge	

*General medical care provided by a Participating Provider

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgery		
Professional	20%	Coinsurance after Deductible
Facility	20%	Coinsurance after Deductible
Specialized Scanning Services (e.g., CT Scan, PET Scan, MRI)	20%	Coinsurance after Deductible
Radiology Services (e.g., X-Rays)	$30	Copayment
Laboratory Tests	$10	Copayment
Mental Health (Outpatient Intensive Psychiatric Treatment Programs)	20%	Coinsurance after Deductible
Inpatient Hospital Services	**At Participating Providers, You Pay**	
Medical / Surgical		
Professional	20%	Coinsurance after Deductible
Facility	20%	Coinsurance after Deductible
Maternity Care (Professional and Facility Services)	20%	Coinsurance after Deductible
Mental Health (Inpatient Psychiatric Hospitalization)	20%	Coinsurance after Deductible
Substance Abuse		
Inpatient Detoxification	20%	Coinsurance after Deductible
Transitional Residential Recovery Services	20%	Coinsurance after Deductible
Skilled Nursing Facility (Limited to 30 days per calendar year)	20%	Coinsurance after Deductible
Hospice Care	No Charge	
Prescription Drug Coverage*	**At Participating Providers, You Pay**	
Tier-1 Formulary Generic Drugs	$5	Copayment
Tier-2 Formulary Preferred Brand Name Drugs	$30	Copayment
Tier-3 Formulary Non-Preferred Brand Name Drugs	20%	Coinsurance
Tier-4 Formulary Specialty (Oral and Injectable) Drugs (Maximum Cost Sharing of $100 for a 30-day supply of oral chemotherapy drugs)	20%	Coinsurance
Tier-5 Formulary Preventive Drugs	No Charge	
Mail-Order Prescription Drugs (Applies only to Drug Tiers 1, 2, 3 & 5.)	A 90-day supply is offered at two times the 30-day prescription Cost Sharing.	

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

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	20%	Coinsurance
Home Healthcare (Limited to 60 visits per calendar year)	No Charge	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	$150	Copayment per trip
Hearing Aids (Limited to 1 device per ear every 3 years)	20%	Coinsurance
Other Services	**At Participating Providers, You Pay**	
Dialysis Services	$30	Copayment

TABLE OF CONTENTS

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

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

WELCOME

Welcome to Molina Healthcare!

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

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

Molina Healthcare is a Wisconsin licensed Health Maintenance Organization.

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

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
www.molinahealthcare.com/marketplace

If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

INTRODUCTION

Thank You for Choosing Molina Healthcare as Your Health Plan.

This document is Your "Molina Healthcare of Wisconsin, Inc. Agreement and Individual Evidence of Coverage" (Your "Agreement" or "EOC"). This EOC tells You how You can get services through Molina. It 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 (PCP).
- Make a payment.
- Make an appointment.

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

Call Us toll-free at **1 (888) 560-2043** from 8:00 a.m. to 5:00 p.m. CT. We are here Monday through Friday. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

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

Right to Return Agreement

Please read this Agreement carefully. If You are not satisfied with Your Agreement, You can return it to Us within 10 days of Your receipt of the Agreement. If You return it to Us within the 10-day period, We will treat this Agreement as if it had never been issued. We will return all of Your Premium payments to You. If You return this Agreement under this provision, You will be responsible for payment of any health care service You or a Dependent received before You returned the Agreement.

Renewability

This EOC remains in effect at the option of the Subscriber, except as provided in the "Renewal and Termination" section of this EOC.

YOUR PRIVACY

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

Your Protected Health Information

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

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

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

When does Molina need Your written authorization (approval) to use or share Your PHI?
Molina needs Your written approval to use or share Your PHI for reasons not listed above.

What are Your privacy rights?

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

How does Molina Healthcare protect Your PHI?
Molina uses many ways to protect PHI. This includes written or spoken PHI. It includes PHI in a computer. Here are some ways Molina protects PHI:

- We have policies and rules to protect PHI.
- We limit who may see PHI. Only Molina staff who need to know PHI may use it.
- Our staff is trained on how to protect and secure PHI.
- Our staff must agree in writing to follow the rules and policies that protect and secure PHI.
- We secure PHI in Our computers. PHI in Our computers is kept private with 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 is in the next section of this EOC. It is on Our website at www.molinahealthcare.com. You may also get a copy of Our Notice of Privacy Practices. Call Our Customer Support Center at 1 (888) 560-2043. If You are deaf or hard of hearing, You may call Us by dialing 7-1-1 for the Telecommunications Relay Service.**

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF WISCONSIN, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT TELLS YOU HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Molina Healthcare of Wisconsin**,** Inc. (“**Molina Healthcare,**” “**Molina,**” “**We,**” “**Our,**” or “**Us**”) uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment. We use it for 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.

Why does Molina Healthcare use or share Your PHI?

We use or share Your PHI to provide You with health care 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 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 may use or share Your PHI to run Our health plan. For example, We may use Your claims PHI to tell You about programs that could help You. We may use or share Your PHI to solve a Member concern. Your PHI may be used to make sure claims are paid right.

Health care operations can include:

- Improving quality
- Actions in health programs to help Members with certain conditions (such as asthma)
- Doing or arranging for medical review
- Legal services

- Fraud and abuse detection programs
- Actions to help Us obey laws
- Addressing Member needs
- Solving complaints and grievances

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

When can Molina use or share Your PHI without getting written authorization (approval) from You?

The law allows or requires Molina to use and share Your PHI for several other reasons listed here:

Required by law

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

Public Health

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

Health Care Oversight

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

Research

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

Law Enforcement

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

Health and Safety

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

Government Functions

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

Victims of Abuse, Neglect or Domestic Violence

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

Workers' Compensation

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

Other Disclosures

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

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

Molina needs Your written approval to use or share Your PHI for any reason not listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given Us. Your cancellation will not apply to actions already taken by Us.

What are Your health information rights?

You have the right to:

- **Request Restrictions on 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 or other persons You name who help 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'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. This may include records used in making coverage, claims and other decisions as a Molina Member. You will need to make Your request in writing. You may use Molina's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases, We may deny the request. *Important Note: We do not have complete copies of Your medical records. If You want to look at, get a copy of, or change Your medical records, please contact Your doctor or clinic.*

- **Amend Your PHI**

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

- **Receive an Accounting of How We Share Your PHI**

  You may ask that We give You a list of certain parties that We shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:

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

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

You may make any of the requests listed above. You can get a paper copy of this Notice. Please call Our Customer Support Center at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

What can You do if Your rights have not been protected?

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

You may complain to Us at:

Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 847-1778

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
1 (800) 368-1019; 1 (800) 537-7697 (TDD)
Fax: 1 (312) 886-1807

What are the duties of Molina Healthcare?

Molina is required to:

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

This Notice is Subject to Change

Molina 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
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
TTY 7-1-1

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 and are capitalized throughout this EOC.

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

"**Annual Out-of-Pocket Maximum**"

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

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

"**Benefits and Coverage**" (also referred to as "**Covered Services**") means the health care services available under the terms of this Agreement.

"**Child-Only Coverage**" means coverage under this Agreement to provide benefit coverage only to a child who, as of the beginning of a plan year, has not attained the age of 21, and meets all other eligibility requirements for coverage under this product.

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

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

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

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Benefits and Coverage Guide at the beginning of this EOC.

Please refer to the Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

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

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 the "Eligibility and Enrollment" section of this EOC.

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

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

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in: 1) placing the health of the Member in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

"**Emergency Services**" means 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. EHB 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 are not covered under this EOC. These dental services can be purchased separately through a stand-alone dental product that is certified by the Marketplace.

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

"**Habilitative Services**" means 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.

"**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 Wisconsin 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 this Agreement, the term refers to the Marketplace operating in the State of Wisconsin, however it may be organized and run.

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

- In accordance with generally accepted standards of medical practice;

- Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and

- Not primarily for the convenience of the patient, physician, or other health care provider. The services must not be more costly than an alternative service or sequence of services. They are 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 Dependent and a Subscriber, unless the Subscriber is not applying for coverage on their own behalf, but is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a minor child who, as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this product but will not be a Member. Throughout this EOC, "You" and "Your" may be used to refer to a Member or Subscriber, as the context requires.

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

"**Molina Healthcare of Wisconsin, Inc.**" **(**also "**Molina Healthcare**" or "**Molina**" or "**We**" or "**Our**" or "**Us**"**)** means the corporation licensed in the State of Wisconsin as a health maintenance organization, and contracted with the Marketplace.

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

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

"**Out-of-Area Service**" means a service that is provided outside of the Service Area and is not a Covered Service, except as otherwise stated in this Agreement.

"**Participating Provider**" refers to those providers, including hospitals and physicians, that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

"**Premiums**" mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

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

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

"**Prior Authorization**" means Molina's decision to approve specialty or other Medically Necessary care for a Member before services are provided. A Prior Authorization is sometimes called an "approval" or "authorization."

"**Service Area**" means the geographic area in Wisconsin where Molina Healthcare has been authorized by the Wisconsin Office of the Commissioner of Insurance and the Centers of Medicare and Medicaid Services to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide Covered Services through approved individual health plans sold through the Marketplace.

"**Specialist Physician**" means any licensed, board-certified, or board-eligible physician who practices a specialty and who is a Participating Provider.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this EOC, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple and have filed a declaration of domestic partnership with the appropriate Wisconsin county clerk and meet all the requirements of Wisconsin law (sometimes referred to as a "Domestic Partnership" herein).

"**Subscriber**" means either:

- An individual who is a resident of Wisconsin, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina Healthcare as the Subscriber, and has maintained membership with Molina Healthcare in accordance with the terms of this Agreement. This includes an individual who is not a minor and is applying on their own behalf for Child-Only Coverage under this Agreement; or
- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a minor child, who as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of the Member under this Agreement. Throughout this EOC, "You" and "Your" may be used to refer to a Member or a Subscriber, as the context requires.

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

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?

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

For coverage during the calendar year 2016, the initial open enrollment period begins November 1, 2015 and ends January 31, 2016. Your Effective Date for coverage during 2016 will depend on when You applied:

- If You applied on or before December 15, 2015, the Effective Date of Your coverage is January 1, 2016.
- If You applied from December 16, 2015 through January 15, 2016, the Effective Date of Your coverage is February 1, 2016.
- If You applied from January 16, 2016 through January 31, 2016, the Effective Date of Your Coverage is March 1, 2016.

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. In such case, the Effective Date of coverage will be determined by the Marketplace. The Marketplace and 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. The Marketplace establishes the eligibility requirements. Check the Marketplace's website at healthcare.gov for eligibility criteria. Molina requires You to live in Our Service Area to be eligible under this product. For Child-Only Coverage, the Member must be under the age of 21 at the beginning of the plan year, and in the case of a Subscriber who applies for coverage on behalf of a minor child, the Subscriber must be a responsible adult (parent or legal guardian). If You have lost Your eligibility, You may not be able to re-enroll. This is described in the section titled "When Will My Molina Membership End? (Termination of Benefits and Coverage)."

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

Dependents: Subscribers who enroll during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents. This is established by the Marketplace.

Dependents must meet the eligibility requirements. Dependents must live in Our Service Area to be eligible under this product. The following family members are considered Dependents under an Agreement that is not for Child-Only Coverage (refer to "Child-Only Coverage" section, above, for information on adding children to Child-Only Coverage):

- Spouse
- Children: The Subscriber's children or the Spouse's children (including legally adopted children, foster children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Grandchildren: When a Dependent child of the Subscriber has children (i.e., the Subscriber's grandchildren), then such grandchildren may qualify as Dependents of the Subscriber. Grandchildren are eligible for coverage under this product until the enrolled Dependent child who is the parent turns 18.

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

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

Molina will provide the Subscriber with notice at least 90 days before the enrolled child reaches the limiting age. At this time, the Dependent child's coverage will end.

The Subscriber must give Molina proof of his or her child's incapacity and dependence. This must happen within 60 days of receiving such notice from Molina. This must occur in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina. Proof of incapacity may be requested annually after the two-year period immediately following attainment of the limiting age by the child.

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 eligibility criteria described above.

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

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

- **Spouse**: You can add a Spouse as long as You apply during the open enrollment period. 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 (involuntary loss of coverage)
    - Individual market plans
    - Any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act

  - The date of Your marriage or the date Your Domestic Partnership is filed with the appropriate county register of deeds;
  - 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, except in Child-Only Coverage. You must apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

  - The child loses "minimum essential coverage" through:

    - Government sponsored programs
    - Employer-sponsored plans (involuntary loss of coverage)
    - Individual market plans
    - Any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act

  - The child becomes a Dependent through marriage, Domestic Partnership, birth, adoption, placement for adoption, placement in foster care, or child support or other court order.
  - The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
  - The child permanently moves into the Service Area.

- **Adult Children Who Are Students Called to Active Duty:** Your adult child age 26 and older can be covered, except in Child-Only Coverage. The child must be:

  - Attending an accredited vocational, technical, adult education school or college.
  - A full-time student, which means the child is:

    - Taking 12-15 credits per semester; or
    - A full-time student as defined by the institution that the student is attending.

The child will continue to be eligible for coverage. This is regardless of age. The adult child must meet all of the following eligibility criteria:

- The child was called to federal active duty in the National Guard or in a reserve component of the United States Armed Forces. This happened while the child was attending, on a full-time basis, an institution of higher education; and
- The child was under the age of 27 when called to federal active duty.

We may require proof upon initial enrollment, and annually thereafter, that Your adult child meets these eligibility criteria.

Once such adult child is no longer attending school as a full-time student, he or she will no longer be eligible for coverage under this EOC. However, if such adult child ceases to be a full-time student due to a Medically Necessary leave of absence; and this Medically Necessary leave of absence is documented and certified by such child's practitioner, coverage will continue until the earlier of the date:

- The child advises Us that he or she does not intend to return to school on a full-time basis;
- The adult child becomes employed on a full-time basis;
- The adult child obtains other health care coverage;
- The adult child marries and is eligible for coverage under his or her Spouse's healthcare coverage;
- Your coverage is discontinued or not renewed; or
- One year has elapsed from the date the adult child ceased to be a full-time student and he or she has not returned to school on a full-time basis.

We may require proof of the adult child's full-time student enrollment on an as-needed basis. A full-time student who finishes the spring term shall be deemed a full-time student throughout the summer if the student has enrolled as a full-time student for the following fall term, regardless of whether such adult child enrolls for the summer term.

- **Newborn Child:** Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 60 days, the newborn is covered for only 31 days beginning on the newborn child's date of birth. Within one year of the newborn child's birth, You may enroll the child after 60 days if You make all past due Premium payments with 5.5% interest.

- **Adopted Child:** A newly adopted child or child placed with You or Your Spouse for adoption is covered from whichever date is earlier:

  - The date of adoption or placement for adoption; or
  - The date You or Your Spouse gain the legal right to control the child's health care.

  If You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. Coverage begins on the date of adoption, placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier.

For purpose of this requirement, "legal right to control health care" means You or Your Spouse has a valid signed written document. This can be:

- A health facility minor release report;
- A medical authorization form;
- A relinquishment form; or
- Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

- **Court Order or Child Support Order**

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

- **Foster Child**

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

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

Discontinuation of Dependent Benefits and Coverage: Except under Child-Only Coverage, Benefits and Coverage for Your Dependent will be discontinued on:

- The end of the calendar year that the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)".
- The date the Dependent Spouse enters a final decree of divorce, annulment, termination of the Domestic Partnership, or dissolution of marriage from the Subscriber.

If You are no longer eligible for coverage under 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 PCP's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care.

If You lose Your ID card, call Us toll-free at **1 (888) 560-2043**. We will send You a new ID card. Call Us if You have questions about how to use Your health care benefits.

Sample ID Card

Front:

Back:

What Do I Do First?

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

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Your PCP's name (Provider)
- Your PCP's office phone number (Provider Phone)
- The name of the medical group Your PCP works with (Provider Group)
- Molina's 24-hour Nurse Advice Line toll free number
- The toll-free number to Nurse Advice Line in Spanish
- Toll-free number for prescription related questions
- The identifier for Molina's prescription drug benefit
- Toll-free number to notify Molina that You have been admitted to the hospital
- Toll-free number to notify Molina that You have gone to the emergency room.

Your ID card is used by health care providers such as Your PCP, a pharmacist, or a hospital. It helps them know Your eligibility for services through Molina. When You go for care, You may be asked to present Your ID card before getting services.

ACCESSING CARE

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

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

Molina's Provider Directory includes a list of the PCPs and hospitals. These are available to You as a Molina Member. You may visit Our website at **www.molinahealthcare.com/marketplace**. Here You can view Our online list of Participating Providers.

The first person You should call for any health care is Your PCP. If You need hospital or similar services, You must go to a facility that is a Participating Provider. We can tell You about facilities that are with Molina or where they are located. Call Molina toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service. You may get Emergency Services or out-of-area Urgent Care Services in any emergency room or urgent care center.

Except for Emergency Services and out-of-area Urgent Care Services, 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.

This chart is to help You know where to go for medical care. The services You may need are listed in the boxes on the left. The right side tells You who to call or where to go.

ALWAYS CONSULT YOUR PCP FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE.	
TYPE OF HELP YOU NEED:	**WHERE TO GO. WHO TO CALL.**
Emergency Services	Call **911** or go to the nearest emergency room. Even when outside Our 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 1 (888) 275-8750** **Spanish 1 (866) 648-3537** **English TTY 1 (866) 735-2929** **Spanish TTY 1 (866) 833-4703** For out-of-area Urgent Care Services, go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP

ALWAYS CONSULT YOUR PCP FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE.	
TYPE OF HELP YOU NEED:	**WHERE TO GO. WHO TO CALL.**
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization for these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization for these services.
To see an OB/GYN (woman's doctor).	Women may go to any Participating Provider OB/GYN without a referral or Prior Authorization. Ask Your doctor or call Molina's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a qualified mental health 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	Go to a qualified mental health or substance abuse Participating Provider. You do not need a referral. You do not need a Prior Authorization for outpatient office visits.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to a Specialist Physician who is a Participating Provider. A referral from your PCP is not required. If You need Emergency Services or out-of-area Urgent Care Services, see "Emergency Services" or "Urgent Care Services" above.
To have surgery	Go to Your PCP first. If You need Emergency Services or out-of-area Urgent Care Services, see "Emergency Services" or "Urgent Care Services" above.
To get a second opinion	Consult Molina's Provider Directory on Our website. You can find a Participating Provider for a second opinion. Go to: www.molinahealthcare.com/marketplace.
To go to the hospital	If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under "Emergency Services" or "Urgent Care Services" above. For non-emergency, go to Your PCP first, or go to any hospital facility that is a Participating Provider.
After-hours care	You can call Molina's 24-Hour Nurse Advice Line. **Toll-free: 1 (888) 275-8750** **Spanish: 1 (866) 648-3537** **English TTY: 1 (866) 735-2929** **Spanish TTY: 1 (866) 833-4703** You have the right to interpreter services at no cost to You to help in getting after hours care. Call Molina Customer Support toll-free **1 (888) 560-2043**.

What Is a Primary Care Provider (PCP)?

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

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 Healthcare doctors, call Us. Molina's Customer Support Center number is toll-free at **1 (888) 560-2043**. We are here between 8:00 a.m. and 5:00 p.m. CT, Monday through Friday. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

Choosing Your Doctor (Choice of Physician and Providers)

For Your health care to be covered under this product, Your health care services must be provided by Molina Participating Providers. This includes doctors, hospitals, Specialist Physicians or medical clinics. The exception is Emergency Services or out-of-area Urgent Care Services. For more information, please refer to the section titled "Emergency Services and Urgent Care Services."

Our Provider Directory will help You get started in making decisions about Your health care. You will find a list of doctors and hospitals that are available under this Agreement. You will also learn some helpful ways to use the services and benefits covered under this Agreement. Visit Molina's website at **www.molinahealthcare.com/marketplace** for more information.

In Molina's Provider Directory, You will find:

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

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

Note: Some hospitals and providers may not provide some of the services that may be covered under this EOC that You or Your family member might need. This may include family planning, birth control, 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. You can call the Customer Support Center toll-free at 1 (888) 560-2043. You can make sure that You can get the health care services that You need. If You are deaf or hard of hearing, You may call Us by dialing 7-1-1 for the Telecommunications Relay Service.

How Do I Choose a PCP?

It is easy to choose a PCP. Use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or You may want to choose one doctor for You and another one for Your family members.

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

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

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service. Molina can 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. We can tell You more about Your Molina doctor.

What if I Do Not Choose a PCP?

Molina asks that You select a PCP. However, if You do not choose a PCP, Molina will choose one for You.

Changing Your Doctor

What if I Want to Change My PCP?

You can change Your PCP at any time. All changes will be effective the following business day. But first, visit Your doctor. Get to know Your PCP before changing. Having a good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina Healthcare doctor.

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

Your doctor may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior).
- You are being abusive, threatening or have violent behavior.
- Your relationship with Your PCP breaks down.

How Do I Change My PCP?

Call Molina toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service. You may also view Our online list of doctors on Our website. Go to Molina's website at **www.molinahealthcare.com/marketplace**. We can help You make the change.

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

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

What if My Doctor or Hospital Is No Longer With Molina Healthcare?

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

If You are assigned to a PCP or hospital that is ending a contract with Molina, then We will give You 30 days' advance written notice. We will let You know of the contract ending between Molina and the PCP or hospital.

You may be getting care from a doctor or hospital that is ending a contract with Molina. You may have a right to keep the same doctor or get care at the same hospital for a given time period. Please contact Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 847-1778
www.molinahealthcare.com/marketplace

You may have more questions or a complaint. You may contact the Wisconsin **OFFICE OF THE COMMISSIONER OF INSURANCE** as follows:

Phone:
1 (800) 236-8517 (outside Madison), or
1 (608) 266-0103 (in Madison)

Mailing Address:
OFFICE OF THE COMMISSIONER OF INSURANCE
P.O. Box 7873
Madison, Wisconsin 53707-7873

E-mail:
ocicomplaints@wisconsin.gov

Please indicate Your name, phone number, and e-mail address on Your correspondence.

Deaf, hearing, or speech-impaired callers may reach the **OFFICE OF THE COMMISSIONER OF INSURANCE** by dialing **7-1-1** (TTY) and asking for **1** (**608) 266-3586**.

Continuity of Care

If a provider's participation in the network has ended, We will cover services if We presented the provider as a Participating Provider in the marketing materials that We gave You or were available at the most recent open enrollment period.

If You are undergoing a course of treatment with a former Participating Provider who is no longer available, We will provide coverage for the remainder of the course of treatment or 90 days, whichever is shorter. If maternity care is the course of treatment and the Member is in her 2nd or 3rd trimester of pregnancy, We will provide coverage until the completion of postpartum care for the mother and infant.

Coverage will not be provided if the provider no longer practices in the Service Area or We terminate the provider's contract for misconduct on his/her part.

If You want to request that You stay with the same doctor or hospital for continuity of care, call Us. Molina's Customer Support Center number is toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

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

24-Hour Nurse Advice Line

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

Toll-free: 1 (888) 275-8750
Spanish: 1 (866) 648-3537
English TTY: 1 (866) 735-2929
Spanish TTY: 1 (866) 833-4703

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

Receiving Covered Services Promptly

You should be able to receive Covered Services from a Participating Provider within a time that is reasonably prompt for Your local area and community.

What Is a Prior Authorization?

A Prior Authorization is a request for You to receive a Covered Service from Your doctor. Molina's Medical Director and Your doctor work together. They decide on the Medical Necessity before the care or service is given. This is to ensure it is the right care for Your specific condition.

You do not need Prior Authorization for the following services:

- Diagnosis or treatment plan for Autism Spectrum Disorder
- Emergency Services or Urgent Care Services
- Family planning services
- Human Immunodeficiency Virus (HIV) testing and counseling
- Manipulative treatment services, including chiropractic services
- Mental health and substance abuse outpatient services, other than the following:
  - Mental health inpatient
  - Substance abuse inpatient services
  - Partial hospitalization
  - Day Treatment
  - Intensive Outpatient Programs (IOP)
  - Electroconvulsive Therapy (ECT)
  - Neuropsychological and Psychological Testing
- OB/GYN services (Female Members may self-refer to an OB/GYN)
- Office-based procedures
- Services for sexually transmitted diseases

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

- Approved clinical trials
- 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*
- Certain mental health and substance abuse services*
  - Mental health inpatient
  - Substance abuse inpatient services
  - Partial hospitalization
  - Day treatment
  - Intensive Outpatient Programs (IOP)
  - Electroconvulsive Therapy (ECT)
  - Neuropsychological and psychological testing
- 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
- Dialysis (notification only, Prior Authorization is not required)
- Drug quantities that exceed the day-supply limit
- Experimental or Investigational procedures
- Formulary Specialty (Oral and Injectable) drugs
- General anesthesia for dental care in Members 5 years old or older
- Habilitative services (after 6 visits for outpatient and home settings)
- Home healthcare (after 6 visits for outpatient and home settings)
- Hospice inpatient care (notification only, Prior Authorization is not required)
- Imaging and special tests. Examples are:
  - CT (Computed Tomography)
  - MRI (Magnetic Resonance Imaging)
  - MRA (Magnetic Resonance Angiogram)
  - PET (Positron Emission Tomography) scan
- Inpatient admissions
- Low vision follow-up care
- Medically Necessary genetic testing for high risk pregnancies
- Pain management services and procedures
- Pregnancy and delivery (notification only, Prior Authorization is not required)
- Radiation therapy and radio surgery
- Rehabilitative services
  - Cardiac and Pulmonary Therapy
  - Occupational Therapy (after 6 visits for outpatient and home settings)
  - Physical Therapy (after 6 visits for outpatient and home settings)
  - Speech Therapy (after 6 visits for outpatient and home settings)
- Services rendered by a Non-Participating Provider
- Transplant evaluation and related services including Solid Organ and Bone Marrow (Cornea transplant does not require Prior Authorization)
- Wound therapy
- Any other services listed as requiring Prior Authorization in this EOC

*****Call Molina's Customer Support Center at **1 (888) 560-2043**. You can find out if Your service needs Prior Authorization. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

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

Approvals are given based on Medical Necessity. You or Your Participating Provider may call for Prior Authorization; however, You are ultimately responsible for requesting the Prior Authorization. If You have questions about how a certain service is approved, call Molina toll-free at **1 (888) 560-2043** 24 hours a day. If You are deaf or hard of hearing, You may call Us by dialing **7-1-1** for the Telecommunications Relay Service.

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.

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

Medical conditions that may cause a serious threat to Your health are processed within 72 hours. This is 72 hours from the time We get all the information We need and ask for to make the decision. The period of time required may be shorter under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina Healthcare processes requests for urgent specialty services right away. This is done 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 also noted in the section of this EOC titled "Grievances (Internal Appeals) And External Appeals."

Standing Approvals

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

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

To get a standing approval, call Your PCP. Your PCP will work with Molina's physicians and Specialist Physicians to ensure You receive a treatment plan based on Your medical needs. If You have any difficulty getting a standing approval, call Molina Healthcare toll-free at **1 (888) 560-2043**.

If You are deaf or hard of hearing, You may contact Us by dialing 7-1-1 for the Telecommunications Relay Service. If after calling Molina You feel Your needs have not been met, please refer to Our complaint process, which is described in the section of this EOC titled "Complaints."

If the standing approval is approved, You may request that a designated Specialist Physician provide primary care services.

Second Opinions

You or Your PCP may want another doctor (a PCP or Specialist Physician) to review Your condition. This doctor looks at Your medical record and may see You. This new doctor may suggest a plan of care. This is called a second opinion.

Please consult Our Provider Directory online at **www.molinahealthcare.com/marketplace** to find a Participating Provider for a second opinion. We only cover second opinions when furnished by a Participating Provider.

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

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

EMERGENCY SERVICES AND URGENT CARE SERVICES

What Is an Emergency?

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

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

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

Emergency Services also includes Emergency contraceptive drug therapy.

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

How Do I Get Emergency Services?

Emergency Services are available 24 hours a day, seven days a week for Molina Healthcare Members.

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

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

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

If You are not sure if You need Emergency Services but You need medical help, call Your PCP. Or call Our 24-Hour Nurse Advice Line toll-free at **1 (888) 275-8750** or, for Spanish, at **1 (866) 648-3537**. The Nurse Advice Line is staffed by Registered Nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year.

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

What if I Am Away From Our Service Area and I Need Emergency Services?

Go to the nearest emergency room for care. Please contact Molina Healthcare within 48 hours, or when medically reasonable, of getting Urgent Care Services or Emergency Services. Call toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service. When You are away from Our Service Area, only Urgent Care Services or Emergency Services are covered.

What If I Need After-Hours Care or Urgent Care Services?

Urgent Care Services are available when You are within or outside of Our Service Area. Urgent Care Services are those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services, for directions, call Your PCP or Our 24-Hour Nurse Advice Line toll-free at **1 (888) 275-8750**, or for Spanish, at **1 (866) 648-3537**. If You are deaf or hard of hearing, please use the Telecommunications Relay Service by dialing **7-1-1**. Our nurses can help You any time of the day or night. They will tell You what to do or where to go to be seen.

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

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

You have the right to interpreter services at no cost to You to help in getting after-hours care. Call Our 24-Hour Nurse Advice Line toll-free at **1 (888) 275-8750**, or for Spanish, at **1 (866) 648-3537**. If You are deaf or hard of hearing, please use the Telecommunications Relay Service by dialing **7-1-1**.

Emergency Services Rendered by a Non-Participating Provider

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

When services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina will calculate the allowed amount that will be covered under this benefit as the greater 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 Medicare rate for such services. **You may be responsible for charges that exceed the allowed amount covered under this benefit.**

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

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

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems and teach You how to manage them better. The nurse may also work with Your family or caregiver and provider to make sure You get the care You need.

There are several ways You can be referred for this program. There are also certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll free at **1 (888) 560-2043**.

Pregnancy
What if I am pregnant?

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

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

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

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits under this Agreement, You must pick an OB/GYN or nurse practitioner who is a Participating Provider. If You need help choosing an OB/GYN or if You have any questions, call Molina Healthcare toll-free at **1 (888) 560-2043**, Monday through Friday from 8:00 a.m. to 5:00 p.m. CT. We will be happy to assist You.

Molina Healthcare offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. For more information, call the Motherhood Matters® pregnancy program toll-free at **1 (866) 891-2320**, Monday through Friday, 10:30 a.m. to 7:30 p.m. CT.

ACCESSING CARE FOR MEMBERS WITH DISABILITIES

Americans With Disabilities Act

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

Physical Access

Molina Healthcare has made every effort to ensure that Our offices and the offices of Molina Healthcare doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina Healthcare toll-free at **1 (888) 560-2043** and a Customer Support Center Representative will help You find another doctor. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

Access for the Deaf or Hard of Hearing

Call Our Customer Support Center at **1 (888) 560-2043** or by dialing **7-1-1** for the Telecommunications Relay Service.

Access for Persons With Low Vision or Who Are Blind

This EOC and other important product materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This EOC is also available in an audio format.

For accessible formats, or for direct help in reading the EOC and other materials, please call Molina Healthcare toll-free at **1 (888) 560-2043**. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Our Customer Support Center.

Disability Access Grievances

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

BENEFITS AND COVERAGE

Molina Healthcare covers the services described in the section below titled "What is Covered Under My Plan?" These services are subject to the exclusions, limitations, and reductions set forth in this EOC and are only covered if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services.
- The Covered Services are Medically Necessary.
- The services are listed as Covered Services in this EOC.
- You receive the Covered Services from Participating Providers inside Our Service Area for this product offered through the Marketplace, except where specifically noted to the contrary in this EOC. For example, in the case of an Emergency or need for out-of-area Urgent Care Services, You may receive Covered Services from providers outside the Service Area.

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

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits. The Affordable Care Act requires preventive services. They will be provided by Participating Providers. Cost Sharing for Covered Services is listed in the Benefits and Coverage Guide at the beginning of this EOC. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members. This is determined by the Marketplace's rules.

YOU SHOULD REVIEW THE BENEFITS AND COVERAGE GUIDE CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

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

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

Coinsurance

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

Copayment

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

Deductible

The Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Benefits and Coverage Guide at the beginning of this EOC.

Please refer to the Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

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

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

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

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

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing, unless specifically stated or until You pay the applicable Annual Out-of-Pocket Maximum. Please refer to the Benefits and Coverage Guide at the beginning of this EOC. You will be able 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. You must also have had no break in coverage. If the services are not covered under Your prior health plan, You pay the Cost Sharing in effect on the date You received 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 a portion of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this EOC. However, You are responsible for paying charges for any health care services or treatment that are <u>not</u> Covered Services under this EOC, which may include charges for any health care services provided by a Non-Participating Provider

How Your Coverage Satisfies the Affordable Care Act

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

The Affordable Care Act provides certain rules for EHB. 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 EHB 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 that You pay for all EHB does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay to receive EHB. Such Cost Sharing includes Deductibles, Coinsurance, Copayments and/or similar charges. Cost Sharing 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 EHB.
- For information about any annual limits on Cost Sharing towards Your Essential Health Benefits.
- To assist You in determining whether You are a qualifying American Indian or Alaska Native who has limited or no Cost Sharing responsibilities for EHB. Molina will work with the Marketplace 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 known as Your Benefits and Coverage or Covered Services.

For a service to be covered, **it must be Medically Necessary**.

You have the right to appeal if a service is denied. For information on how You can have Your case reviewed, refer to the "Grievances (Internal Appeals) and External Appeals" section of this EOC.

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

Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization *before* seeking treatment for such services. To read more about Prior Authorization and a complete list of Covered Services that require Prior Authorization, turn to the section of this EOC titled "What Is A Prior Authorization?" Prior Authorization does not apply to Emergency Services or Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

PREVENTIVE CARE AND SERVICES
Preventive Services and the Affordable Care Act

Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services. You do not pay any Cost Sharing for:

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

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

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

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

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

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

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

Preventive Services for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay any Cost Sharing if services are furnished by a Participating Provider: Not all procedures are preventive. Talk to Your provider about the specific indications for Your service.

- Complete health history
- Physical exam including growth assessment
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Basic vision screening (non-refractive)
- Oral health risk assessment for young children (ages 0-10) (1 visit per 6-month period)
- Hearing screening for newborns
- Immunizations*****
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections
- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health education
- Lead blood level testing. Parents or legal guardians of Dependent child Members 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.
- All comprehensive perinatal services are covered. These include perinatal and postpartum care, health education, nutrition assessment and psychological services.
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. EPSDT services, including those provided for in the comprehensive guidelines supported by the U.S. Health Resources and Services Administration, are covered for Members under the age of 21. These include those with special health care needs.
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a PCP
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns
- Depression screening: adolescents
- Alcohol and Drug Use assessments for adolescents
- Autism screening for children 18-24 months
- Behavioral health assessment for children
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections.
- Cervical dysplasia screening for sexually active females
- Dyslipidemia screening for children at high risk of lipid disorder

- Hematocrit or hemoglobin screening
- HIV screening for adolescents at higher risk
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk

*****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 preventive care services from a Participating Provider: Not all procedures are preventive. Talk to Your provider about the specific indications for Your service.

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Mammogram for women (based on Your age)
- Pap smear for women (based on Your age) and health status including human papillomavirus (HPV) screening test
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STDs)
- Health education
- Family planning services
- Scheduled prenatal care exams and postpartum follow-up consultations and exams
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies, counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Diabetes (Type 2) screening for adults with high blood pressure
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA screening, counseling about breast cancer preventive medication

- Chlamydial infection screening: women
- Depression screening: adults
- Healthy diet counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Gonorrhea screening and counseling (all women at high risk)
- Behavioral health assessment for adults who are at increased risk for sexually transmitted infections.
- Screening for hepatitis B virus infection in persons at high risk for infection
- 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.
- Tobacco use counseling and interventions
- Well-woman visits
- Screening and counseling for interpersonal and domestic violence: women

PHYSICIAN SERVICES

We cover the following outpatient physician services:

- Prevention, diagnosis, and treatment of illness or injury
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist Physician (for example, a heart doctor or cancer doctor) consultations
- Injections, allergy tests and treatments
- Physician care in or out of the hospital
- Consultations and well-child care
- Routine examinations and prenatal care provided by an OB/GYN to female Members
- Outpatient maternity care including Medically Necessary supplies for a home birth; services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia; services of Other Practitioners, including a certified nurse midwife; and related laboratory services

HABILITATIVE SERVICES

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

REHABILITATIVE SERVICES

We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily living in a setting appropriate for the level of disability or injury.

Outpatient rehabilitative services include only the following:

- Physical Therapy (20-visit limit per calendar year).
- Occupational Therapy (20-visit limit per calendar year). This does not include services described under the "Autism Spectrum Disorders Services" section.
- Speech Therapy (20-visit limit per calendar year). This does not include services described under the "Autism Spectrum Disorders Services" section.
- Pulmonary rehabilitation therapy (20-visit limit per calendar year).
- Cardiac rehabilitation therapy (36-visit limit per calendar year).
- Post-cochlear implant aural therapy (30-visit limit per calendar year).

Benefits can be denied or shortened for Members who are not progressing in goal-directed rehabilitation services. Benefits can also be denied or shortened if rehabilitation goals have previously been met.

Please note that Covered Services include speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, or congenital anomaly. For speech therapy with relation to Autism Spectrum Disorder, please refer to the services described under the "Autism Spectrum Disorders Services" section.

MANIPULATIVE TREATMENT SERVICES

We cover Medically Necessary manipulative treatment services. Manipulative treatment is the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain, and improve function in the management of an identifiable neuromusculoskeletal condition.

OUTPATIENT MENTAL HEALTH SERVICES

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

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

We cover outpatient mental health services 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). The Mental Disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Mental Disorders covered under this EOC 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, or bulimia nervosa.

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

We do not cover services for conditions that the DSM identifies as something other than a Mental Disorder.

We cover mental health clinical assessments of enrolled Dependents who are full-time students attending school in the State of Wisconsin but outside of the Service Area. The clinical assessment must be conducted by a mental health professional designated by Molina. The mental health professional must be located in the State of Wisconsin and in reasonably close proximity to the full-time student's school.

If outpatient mental health or substance abuse services are recommended, coverage will be provided for a maximum of five visits at an outpatient treatment facility. Services may also be received by another provider designated by Molina who is located in the State of Wisconsin and in reasonably close proximity to the full-time student's school.

Molina and the treating provider may conclude that additional treatment is appropriate after completion of five visits. The Member will receive additional treatments as recommended by the treating provider and approved by Molina. Coverage for the outpatient services will not be provided if the recommended treatment would forbid the Dependent from attending school on a regular basis. Coverage would also not be provided if the Dependent were no longer a full-time student. The term "mental health professional" as used in this paragraph means:

- A licensed physician who has completed a residency in psychiatry in an outpatient treatment facility or the physician's office.
- A licensed psychologist.
- A licensed mental health professional practicing within the scope of his or her license.

AUTISM SPECTRUM DISORDER SERVICES

We cover services rendered to a Member who has a primary verified diagnosis of Autism Spectrum Disorder. We will also provide coverage for diagnostic testing for Autism Spectrum Disorders. For the diagnosis to be valid for Autism Spectrum Disorder, the testing tools used must be appropriate to the presenting characteristics and age of the Member. The testing tools must be empirically validated for Autism Spectrum Disorders to provide evidence that the Member meets the criteria for Autism Spectrum Disorders in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

We may require a Member to obtain a second opinion from another health care provider at Our expense. This provider must be experienced in the use of empirically validated tools specific for Autism Spectrum Disorders. The Member, the Member's parent or the Member's authorized representative and Molina must agree upon the provider. Coverage for the cost of a second opinion will be in addition to the benefit mandated by Section 632.895(12m), Wisconsin Statutes, as amended.

Benefits under this provision do not include benefits for Durable Medical Equipment or Prescription Drugs. For coverage of these items, please see the "Durable Medical Equipment" section and the "Prescription Drug Coverage" section.

Definitions That Apply to This Autism Spectrum Disorder Services Section

"Autism Spectrum Disorder" means autism disorder, Asperger's syndrome, or pervasive development disorder not otherwise specified.

"Behavior Analyst" means a person certified by the Behavior Analyst Certification Board, Inc., or successor organization, as a board-certified Behavior Analyst and has been granted a license under Section 440.312, Wisconsin Statutes, to engage in the Practice of Behavior Analysis.

"Behavioral" means interactive therapies that target observable behaviors to build needed skills. These interactive therapies reduce problem behaviors using well-established principles of learning used to change socially important behaviors. The goal is building a range of communication, social and learning skills, as well as reducing challenging behaviors.

"Evidence-Based Therapy" means therapy, service, and treatment that are based upon medical and scientific evidence. Evidence-Based Therapy is determined to be a useful treatment or strategy. It is prescribed to improve the Member's condition or to achieve social, cognitive, communicative, self-care, or behavioral goals. These goals are clearly defined within the Member's treatment plan. To be considered an efficacious treatment or strategy, the therapy must be designed to:

- Address cognitive, social, or Behavioral conditions associated with Autism Spectrum Disorders;
- Sustain and maximize gains made during Intensive-Level Services; or
- Improve an individual with Autism Spectrum Disorder's condition.

"Intensive-Level Services" means evidence-based Behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social, and behavioral deficits linked with that disorder. These therapies must be directly based on, and related to, a Member's therapeutic goals and skills. These goals and skills are prescribed by a physician familiar with the Member. Intensive-Level Services may include evidence-based speech therapy and occupational therapy. These therapies are provided by a Qualified Therapist when such therapy is based on or related to a Member's therapeutic goals and skills and is concomitant with evidence based Behavioral therapy.

"Nonintensive-Level Services" means Evidence-Based Therapies that occur after the completion of treatment with Intensive-Level Services. These are designed to sustain and maximize gains made during treatment with Intensive-Level Services. They are also designed for an individual who has not and will not receive Intensive-Level Services, Evidence-Based Therapies that will improve the individual's condition.

"Practice of Behavior Analysis" means the design, use, and evaluation of systematic instructional and environmental modifications. These modifications are used to produce socially significant improvements in human behavior. These improvements include the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. This includes interventions based on scientific research and the direct observation and measurement of behavior and environment. Practice of Behavior Analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, marriage counseling, psychoanalysis, hypnotherapy, and long-term counseling as treatment modalities.

"Qualified Intensive-Level Professional" means an individual working under the Supervision of an Outpatient Mental Health Clinic who is a licensed treatment professional as defined in Section DHS 35.03(9g), Wis. Admin. Code. This professional has completed at least 2,080 hours of training, education, and experience including all of the following:

- 1,500 hours of supervised training. This training involves direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, efficacious therapy models;
- Supervised experience with all of the following:
    - Working with families as part of a treatment team and ensuring treatment compliance;
    - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;
    - Treating individuals with Autism Spectrum Disorders with a variety of Behavioral challenges;
    - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and
    - Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders; and
- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

"Qualified Intensive-Level Provider" means an individual identified in Section 632.895(12m)(b) 1. to 4., Wisconsin Statutes, acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst. It also means a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy, who provides evidence-based Behavioral therapy in accordance with this provision and Section 632.895(12m)(a) 3., Wisconsin Statutes. This individual has completed at least 2,080 hours of training, education, and experience that includes all of the following:

- 1,500 hours of supervised training involving direct one-on-one work with individuals with Autism Spectrum Disorders using evidence-based, useful therapy models;

- Supervised experience with all of the following:

  - Working with families as the primary provider and ensuring treatment compliance;

  - Treating individuals with Autism Spectrum Disorders who function at a variety of cognitive levels and exhibit a variety of skill deficits and strengths;

  - Treating individuals with Autism Spectrum Disorders with a variety of Behavioral challenges;

  - Treating individuals with Autism Spectrum Disorders who have shown improvement to the average range in cognitive functioning, language ability, adaptive and social interaction skills; and

  - Designing and implementing progressive treatment programs for individuals with Autism Spectrum Disorders; and

- Academic coursework from a regionally accredited higher education institution with demonstrated coursework in the application of Evidence-Based Therapy models. This coursework must be consistent with best practice and research on effectiveness for individuals with Autism Spectrum Disorders.

"Qualified Paraprofessional" means an individual working under the active supervision of a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Provider and who complies with all of the following:

- Is at least 18 years of age;

- Obtains a high school diploma;

- Completes a criminal background check;

- Obtains at least 20 hours of training. This training includes subjects related to Autism Spectrum Disorders, evidence-based treatment methods, communication, teaching techniques, problem behavior issues, ethics, special topics, natural environment, and first aid;

- Obtains at least 10 hours of training in the use of Behavioral Evidence-Based Therapy including the direct application of training techniques with an individual who has Autism Spectrum Disorder present; and

- Receives regular, scheduled oversight by a Qualified Supervising Provider in implementing the treatment plan for the Member.

"Qualified Professional" means a professional acting under the Supervision of an Outpatient Mental Health Clinic certified under Section 51.038, Wisconsin Statutes, acting within the scope of a currently valid state-issued licensed and who provides Evidence-Based Therapy in accordance with this provision.

"Qualified Provider" means an individual acting within the scope of a currently valid state-issued license for psychiatry, psychology, or Behavior Analyst, or a social worker acting within the scope of a currently valid state-issued certificate or license to practice psychotherapy and who provides Evidence-Based Therapy in accordance with this provision.

"Qualified Supervising Provider" means a Qualified Intensive-Level Provider who has completed at least 4,160 hours of experience as a supervisor of less experienced providers, professionals, and paraprofessionals.

"Qualified Therapist" means an individual who is either a speech-language pathologist or occupational therapist acting within the scope of a currently valid state-issued license and who provides Evidence-Based Therapy in accordance with this provision.

"Supervision of an Outpatient Mental Health Clinic" means an individual who meets the requirements of a Qualified Supervising Provider and who periodically reviews all treatment plans developed by Qualified Professionals for Members with Autism Spectrum Disorders.

"Waiver Program" means services provided by the Wisconsin Department of Health Services through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare and Medicaid Services.

Intensive-Level Services Benefit

Covered Services include evidence-based Behavioral Intensive-Level Services, the majority of which are provided to the Member when a parent or legal guardian is present and engaged in the therapy. The therapy must be prescribed by a physician and must meet all of the following requirements:

- Therapy must be based upon a treatment plan developed by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional that includes at least 20 hours per week over a six-month period of time of evidence-based Behavioral intensive therapy, treatment, and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Member to be present and engaged in the intervention;

- Therapy must be implemented by Qualified Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals;

- Therapy must be provided in an environment that is most conducive to achieving the goals of the Member's treatment plan;

- Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Member's family;

- Therapy must begin after a Member is two years of age and before he or she is nine years of age; and

- Therapy must be provided by a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional who directly observes the Member at least once every two months.

Progress must be assessed and documented throughout the course of treatment. We may, at Our option, request and review the Member's treatment plan and the summary of progress on a periodic basis.

The Intensive-Level Services benefit is limited to 30 visits per calendar year. Coverage for Intensive-Level Services will be provided for up to 48 months. We may, at Our option, credit against the required 48 months of Intensive-Level Services any previous Intensive-Level Services the Member may have received prior to enrolling under this product. We may require documentation, including medical records and treatment plans, to verify any evidence-based Behavioral therapy that the Member received for Autism Spectrum Disorders that was provided prior to the Member attaining nine years of age. We may consider any evidence-based Behavioral therapy that was provided to the Member for an average of 20 or more hours per week over a continuous six-month period to be Intensive-Level Services.

Travel time for providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

Benefits are also payable for charges of a Qualified Therapist when services are rendered concomitant with Intensive-Level evidence-based Behavioral therapy and all of the following:

- The Qualified Therapist provides Evidence-Based Therapy to the Member who has a primary diagnosis of an Autism Spectrum Disorder;

- The Member is actively receiving Behavioral services from a Qualified Intensive-Level Provider or Qualified Intensive-Level Professional; and

- The Qualified Therapist develops and implements a treatment plan consistent with their license.

Nonintensive-Level Services Benefit

Covered Services include evidence-based Nonintensive-Level Services, including direct or consultative services, that are provided to a Member by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional either after the completion of Intensive-Level Services to sustain and maximize gains made during Intensive-Level Services or provided to a Member who has not and will not receive Intensive-Level Services but for whom Nonintensive-Level Services will improve the Member's condition. Nonintensive-Level Services must meet all of the following requirements:

- Therapy must be based upon a treatment plan developed by a Qualified Provider, Qualified Professional, or Qualified Therapist that includes specific Evidence-Based Therapy goals that are clearly defined, directly observed, continually measured, and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require the Member to be present and engaged in the intervention;

- Therapy must be implemented by a Qualified Provider, Qualified Professional, Qualified Therapist, or Qualified Paraprofessional;

- Therapy must be provided in an environment most conducive to achieving the goals of the Member's treatment plan; and

- Therapy must implement identified therapeutic goals developed by the team including training, consultation, participation in team meetings, and active involvement of the Member's family.

Progress must be assessed and documented throughout the course of treatment. We may, at Our option, request and review the Member's treatment plan and the summary of progress on a periodic basis.

Travel time for providers will not be included when calculating the number of hours of care provided each week. Benefits are not payable for separately billed travel time.

The Nonintensive-Level Services benefit is limited to 20 visits per calendar year.

Transition to Nonintensive-Level Service

We will provide notice to the Member or the Member's authorized representative regarding a change in the Member's level of treatment. The notice will indicate the reason for transition that may include any of the following:

- The Member has received 48 cumulative months of Intensive-Level Services;

- The Member no longer requires Intensive-Level Services based on supporting documentation from a Qualified Supervising Provider, Qualified Intensive-Level Provider, or Qualified Intensive-Level Professional; or

- The Member is no longer receiving evidence-based Behavioral therapy for at least 20 hours per week over a six-month period of time.

Notice Requirement

The Member or the Member's authorized representative must notify Us at any time in which such Member requires and qualifies for Intensive-Level Services but is unable to receive Intensive-Level Services for an extended period of time. The Member or the Member's authorized representative must indicate the specific reason(s) in which the applicable Member's family or caregiver is unable to comply with the Intensive-Level Services treatment plan. Reasons for requesting Intensive-Level Services to be interrupted for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event, or any other reason that We determine to be acceptable.

We will not deny Intensive-Level Services provided to a Member for failing to maintain at least 20 hours per week of evidence-based Behavioral therapy over a six-month period of time when such Member or Member's authorized representative provides the notice required under this section or when the Member or Member's authorized representative can document that the failure to maintain at least 20 hours per week of evidence-based Behavioral therapy was due to waiting for Waiver Program services.

Non-Covered Services

We will not cover or pay for any expenses incurred for the following:

- Acupuncture
- Animal-based therapy, including hypnotherapy
- Auditory integration training
- Chelation therapy
- Child care fees
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Claims that have been determined by Us to be fraudulent
- Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals
- Treatment rendered by a parent or legal guardian who is otherwise considered a Qualified Provider, Qualified Supervising Provider, Qualified Therapist, Qualified Professional, or Qualified Paraprofessional when the treatment is rendered to his or her own children
- Therapy, treatment, or services provided to a Member who is residing in a residential treatment center, inpatient treatment facility, or day treatment facility
- Costs for a facility or location or use of a facility or location when treatment, services, or Evidence-Based Therapy are provided outside of the Member's home

OUTPATIENT SUBSTANCE ABUSE SERVICES

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

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

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

DENTAL AND ORTHODONTIC SERVICES

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

Dental Services for Radiation Treatment

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

Dental Anesthesia

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

- You are developmentally disabled, Your health is compromised, or Your developmental condition makes anesthesia Medically Necessary;
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center; and
- The dental procedure would not ordinarily require general anesthesia.

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

Dental and Orthodontic Services for Cleft Palate

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

- The services are an integral part of a reconstructive surgery for cleft palate.
- A Participating Provider provides the services or Molina gives Prior Authorization for 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") if all the following conditions apply:

- The condition is caused by a congenital, developmental or acquired deformity, disease or injury.
- Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Covered Services for TMJ are limited to:

- One surgical procedure per calendar year; and
- Three visits per calendar year for:
    - Medically Necessary medical non-surgical treatment of TMJ, including coverage for prescribed intraoral splint therapy devices;
    - 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, for inpatient hospital services, You would pay the Cost Sharing in the "Inpatient Hospital Services" section of the Benefits and Coverage Guide.

Dental Services – Accident Only

Dental services are covered only when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident. You may request an extension of this time period provided that You do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental injury must conform to the following time frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental injury are limited to the following:

- Emergency examination
- Medically Necessary diagnostic X-rays
- Endodontic (root canal) treatment
- Temporary splinting of teeth
- Prefabricated post and core
- Simple minimal restorative procedures (fillings)
- Extractions
- Post-traumatic crowns if such are the only clinically acceptable treatment
- Replacement of lost teeth due to the injury by implant, dentures or bridges

PEDIATRIC VISION SERVICES

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

- Routine vision screening and eye exam every calendar year

- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months
  - Covered frames include a limited selection of covered frames. Participating Providers will show the limited selection of covered frames available to You under this product. Frames that are not within the limited selection of covered frames under this product are not covered.
  - Prescription lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.

- Contact lenses: limited to one pair of standard contact lenses every calendar year, in lieu of prescription lenses and frames; includes evaluation, fitting and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:

  - Aniridia
  - Aniseikonia
  - Anisometropia
  - Aphakia
  - Corneal disorders
  - Irregular astigmatism
  - Keratoconus
  - Pathological myopia
  - Post-traumatic disorders

- Low vision optical devices 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 PCPs and OB/GYN Specialist Physicians are available for family planning services. You can make an appointment without having to get Prior Authorization from Molina. Molina pays the doctor or clinic for the family planning services You receive. Family planning services include:

- Health education and counseling to help You make informed choices and to understand birth control methods
- Limited history and physical examination
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Emergency birth control supplies when filled by a Participating Provider pharmacist, or by a Non-Participating Provider, in the event of an Emergency
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Pregnancy testing and counseling
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Screening, testing, and counseling of at-risk individuals for HIV, and referral for treatment
- Any other outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive

Family planning services do not include:

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

PREGNANCY TERMINATIONS

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

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

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

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

Office Visit and Outpatient Surgery Cost Sharing will apply.

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

OUTPATIENT HOSPITAL/FACILITY SERVICES

OUTPATIENT SURGERY

We cover outpatient surgery services provided by Participating Providers if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room. **Separate Cost Sharing may apply for professional services and facility services.**

OUTPATIENT PROCEDURES (OTHER THAN SURGERY)

We cover 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 SCANNING SERVICES

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

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

We cover radiology services, other than specialized scanning services. Except for Emergency Services and out-of-area Urgent Care Services, 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.

LABORATORY TESTS

We cover the services listed below when Medically Necessary. These services are subject to Cost Sharing. Except for Emergency Services and out-of-area Urgent Care Services, 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.

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

MENTAL HEALTH OUTPATIENT INTENSIVE PSYCHIATRIC TREATMENT PROGRAMS

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

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency Services or out-of-area Urgent Care Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments to the Non-Participating Provider, and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum.

MEDICAL/SURGICAL SERVICES

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by Specialist Physicians
- Anesthesia

- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drug Coverage" in this "What is Covered Under My Plan?" section)
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program), limited to 60 days per year combined for all therapies
- Respiratory therapy
- Medical social services and discharge planning

MATERNITY CARE

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

- Inpatient hospital care for 48 hours after a normal vaginal delivery or 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 Benefits and Coverage Guide for the Cost Sharing that will apply to these services.

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

MENTAL HEALTH INPATIENT PSYCHIATRIC HOSPITALIZATION

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

We cover inpatient mental health services 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). The "Mental Disorder" must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Mental Disorders covered under this EOC 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, or bulimia nervosa.

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

We do not cover services for conditions that the DSM identifies as something other than a Mental Disorder.

We cover mental health services received on a transitional care basis including:

- Services for children and adults in day treatment programs
- Services for persons with chronic Mental Disorders provided through a community support program
- Coordinated Emergency Services for Members who are experiencing a mental health crisis or who are in a situation likely to turn into a mental health crisis if support is not provided. Benefits for these services are to be provided for the time period the Member is experiencing the crisis until he/she is stabilized or referred to another provider for stabilization.

SUBSTANCE ABUSE INPATIENT DETOXIFICATION

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

SUBSTANCE ABUSE TRANSITIONAL RESIDENTIAL RECOVERY SERVICES

We cover substance abuse treatment in a nonmedical transitional residential recovery setting approved in writing by Molina. These settings provide counseling and support services in a structured environment.

SKILLED NURSING FACILITY

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

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

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

The SNF benefit is limited to 30 days per calendar year.

HOSPICE CARE

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

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

The hospice benefit is for Members who are diagnosed with a terminal illness and have a life expectancy of 12 months or less. You can choose hospice care instead of the traditional services covered under this Agreement. Please contact Molina for further information. You must receive Prior Authorization for all inpatient hospice care services.

APPROVED CLINICAL TRIALS

We cover routine patient care costs for qualifying Members participating in approved clinical trials for cancer; cardiovascular disease (cardiac/stroke); surgical musculoskeletal disorders of the spine, hip, and knees; or other diseases or disorders for which We determine the clinical trial is an approved clinical trial (as defined below). You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled for coverage under this product
- Be diagnosed with a condition the prevention, detection or treatment of which is the subject of the approved clinical trial
- Be accepted into the approved clinical trial (as defined below)
- Have received Prior Authorization or approval from Molina

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cardiovascular disease (cardiac/stroke); surgical musculoskeletal disorders of the spine, hip, and knees; or a Covered Service that is not otherwise excluded by this EOC, and:

- 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 Healthcare Research and Quality
    - the Centers for Medicare and Medicaid Services
    - the U.S. Department of Defense
    - the U.S. Department of Veterans Affairs
    - the U.S. Department of Energy

- 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.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit or place conditions on its coverage of Your routine patient costs associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this EOC based on Your health condition or participation in a clinical trial.

The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical trial.

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

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 product include:

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

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

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

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

Reconstructive Surgery Exclusions

The following reconstructive surgery services are not covered:

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

TRANSPLANT SERVICES

We cover transplants of organs, tissue, or bone marrow at participating transplant facilities. These types of transplants are covered if Molina gives Prior Authorization for the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

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

- If either the physician or the transplant facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that determination is made
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accordance with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. Covered Services may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at **1 (888) 560-2043**.

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 inpatient hospital care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Benefits and Coverage Guide.

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

Some drugs on the Drug Formulary require Prior Authorization. Prior Authorization requirements for each drug are indicated in the published Drug Formulary.

We cover prescription drugs and medications when:

- They are ordered by a Participating Provider treating You and the prescription drug is listed in the Molina Drug Formulary or has been approved by Molina's Pharmacy Department.
- They are ordered or given while You are in an emergency room or hospital.
- They are given while You are in a skilled nursing facility. The prescription drug or medication must be ordered by a Participating Provider in connection with a Covered Service. The prescription drug or medication must be filled through a pharmacy in the Molina pharmacy network.
- The prescription drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

We cover Tier-1 Formulary Generic drugs, Tier-2 Formulary Preferred Brand Name drugs, Tier-3 Formulary Non-Preferred Brand Name drugs, Tier-4 Formulary Specialty (Oral and Injectable) drugs, and Tier-5 Formulary Preventive drugs.

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

Prescription drugs are covered outside of the Service Area for Emergency Services or Urgent Care 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) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service. You may view a list of pharmacies on Molina's website: www.molinahealthcare.com/marketplace.

Molina Healthcare Drug Formulary (List of Drugs)

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

You can look at Our Drug Formulary on Our website at www.molinahealthcare.com/marketplace. You may call Us and ask about a drug. Call toll-free **1 (888) 560-2043**, Monday through Friday, 8:00 a.m. to 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the National Telecommunications Relay Service. You can also ask Us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Access to Drugs That Are Not Covered

Molina has a process to allow You, or someone You designate to act on Your behalf, and Your prescribing physician to request and gain access to clinically appropriate drugs that are not covered under Your product. If Your doctor orders a drug that is not listed in the Drug Formulary that he or she believes is best for You, then You, or someone You designate to act on Your behalf, and Your prescribing physician may contact Molina's Pharmacy Department to Prior Authorization for Molina to cover the drug for You. If the request is approved, Molina will contact You, or someone You designate to act on Your behalf, and Your prescribing physician. If the request is denied, Molina will send a letter stating why the drug was denied.

If you are approved for a non-Drug Formulary brand name drug in lieu of a Formulary Generic drug, you will be responsible for payment as described in the section of this Agreement titled "Tier-1 Formulary Generic Drugs."

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You.

Molina may cover specific non-Drug Formulary drugs under the following conditions:

- When Your doctor documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of Your disease or condition; or
- When the Drug Formulary alternative causes or is reasonably expected by Your doctor to cause a harmful or adverse reaction in You.

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

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

You, or someone You designate to act on Your behalf, and Your prescribing physician 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 the initial request is denied, You, someone You designate to act on Your behalf, or Your prescribing physician may request an external review. You, or someone You designate to act on Your behalf, and Your prescribing physician will be notified of the external review decision

no later than:

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

Cost Sharing for Prescription Drugs and Medications

The Cost Sharing for prescription drugs and medications is listed on the Benefits and Coverage Guide. Cost Sharing applies to all drugs and medicines 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 Formulary Generic Drugs

Formulary Generic drugs are those drugs listed in the Molina Healthcare Drug Formulary that have the same ingredients as brand name drugs. To be FDA (government) approved, the Formulary 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. Cost Sharing for Formulary Generic drugs is listed on the Benefits and Coverage Guide. You will be charged a Copayment for Formulary Generic drugs.

If Your doctor orders a brand name drug that is not in the Drug Formulary and there is a Formulary Generic drug available, We will substitute the brand name drug with the Formulary Generic drug.

If Your doctor says that You must have the brand name drug that is not in the Drug Formulary instead of the Formulary Generic drug, then You, or someone You designate to act on Your behalf, and Your prescribing physician must submit a Prior Authorization request to Our Pharmacy Department.

- If Prior Authorization is not obtained from Molina, then You, someone You designate to act on Your behalf, or Your prescribing physician may request an external review, as described in the section of this agreement titled, "Access to Drugs That Are Not Covered."

- If Prior Authorization is obtained from Molina, or if the exception is approved by external review, You may purchase the brand name drug at the following Cost Sharing:
  1. The Cost Sharing for Formulary Non-Preferred Brand Name drugs listed on the Benefits and Coverage Guide, **plus**
  2. The difference in cost between the generic drug and brand name drug.

Tier-2 Formulary Preferred Brand Name Drugs

Formulary Preferred Brand Name drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as "Preferred" in the Molina Healthcare Drug Formulary. Formulary Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina Healthcare and Our pharmacy benefit manager. Cost Sharing for Formulary Preferred Brand Name drugs is listed on the Benefits and Coverage Guide. Deductible may apply, and You will be charged a Copayment for Formulary Preferred Brand Name drugs.

Tier-3 Formulary Non-Preferred Brand Name Drugs

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

Tier-4 Formulary Specialty (Oral and Injectable) Drugs

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.

Molina Healthcare 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. Deductible may apply, and You will be charged Coinsurance for Formulary Specialty (Oral and Injectable) drugs. There is a maximum Cost Sharing of $100 for a 30-day supply of oral chemotherapy drugs.

Tier-5 Formulary Preventive Drugs

Formulary Preventive drugs are drugs listed in the Molina Healthcare Drug Formulary that are considered to be used for preventive purposes, including all methods of birth control drugs or devices for women approved by the FDA, or if they are being prescribed primarily (1) to prevent the symptomatic onset of a condition in a person who has developed risk factors for a disease that has not yet become clinically apparent or (2) to prevent recurrence of a disease or condition from which the patient has recovered. A drug is not considered preventive if it is being prescribed to treat an existing, symptomatic illness, injury or condition. Formulary Preventive drugs are listed on the Benefits and Coverage Guide and are offered at no charge and the Deductible does not apply.

Treatment of HIV

We cover prescription drugs for the treatment of HIV infection or an illness or medical condition arising from or related to HIV that are prescribed by a physician and are approved by the United States Food and Drug Administration (FDA), including Phase III Experimental or Investigational drugs that are FDA approved and are administered according to protocol.

Stop-Smoking Drugs

We cover drugs to help You stop smoking. You will have no Cost Sharing for stop-smoking drugs. You can also learn more about Your stop-smoking options by calling Molina's Health Management & Health Management Level 1 Programs Department toll-free at **1 (866) 472-9483** between 10:30 a.m. and 7:30 p.m. CT, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop-smoking medication.

Mail Order Availability of Drug Formulary Prescription Drugs

Molina offers You a mail order option for prescription drugs on Our Drug Formulary. This option applies only to prescription drug tiers 1, 2, 3 and 5. These prescription drugs can be mailed to You within 10 days from order request and approval. Cost Sharing for a 90-day supply by mail order is two times the Cost Sharing listed on the Benefits and Coverage Guide for a standard 30-day supply.

You may request mail order service in the following ways:

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

Day Supply Limit

The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorization is obtained. The 30-day supply limit may be extended to a 90-day supply for Mail Order.

Diabetic Supplies

Diabetic supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, blood glucose test strips and urine test strips are covered supplies. You will be charged Coinsurance for these supplies. Pen delivery systems for the administration of insulin are also covered and are provided at the Formulary Preferred Brand Name Cost Sharing amount found in the Benefits and Coverage Guide section of this EOC.

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

PROSTHETIC AND ORTHOTIC DEVICES

We cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if **all** of the following requirements are met:

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

Prosthetic and orthotic device coverage includes services to determine whether You need a prosthetic or orthotic device, fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse). If We cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below. Covered Services are limited to a single purchase of each type of prosthetic device every three years.

We do not cover orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.

Internally Implanted Devices

We cover internally implanted prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, hip joints if these devices are determined to be Medically Necessary and 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 Benefits and Coverage Guide to see the Cost Sharing applicable to these devices.

External Devices

We cover the following external prosthetic and orthotic devices, which do not include any device that is fully implanted into the body:

- 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
- Prostheses to replace all or part of an external body part that has been removed or impaired as a result of disease, injury, or congenital defect, to include:
    - Artificial arms, legs, feet, and hands
    - Artificial face, eyes, ears and nose

Durable Medical Equipment Cost Sharing will apply for external devices.

HOME HEALTHCARE

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

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

The following home healthcare 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 60 visits per calendar year (counting all home health visits)

You must have Prior Authorization for home healthcare services after the first 6 visits for outpatient and home settings.

TRANSPORTATION SERVICES
Emergency Medical Transportation

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

HEARING AIDS

We cover hearing aids for a Member of any age if the hearing aid is required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Bone anchored hearing aids are medical/surgical Covered Services under this EOC only for Members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits and Coverage for hearing services are limited to one hearing aid per ear every three years. This limitation does not apply to Dependents under 18 years of age.

Benefits under this section also include hearing aids for Dependent children under 18 years of age, to the extent required under Wisconsin insurance law.

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.
- You or a Participating Provider notifies Molina..

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

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

If You receive health care services while traveling outside the United States, You will be required to pay the Non-Participating Provider's charges at the time You obtain those services. You may submit a claim for reimbursement to Molina for charges that You paid for Covered Services given to You by the Non-Participating Provider.

You are responsible for ensuring that claims and/or records of such services are appropriately translated. You are also responsible for ensuring that the monetary exchange rate is clearly identified when submitting claims for services received outside the United States. Medical records of treatment and service may also be required for proper reimbursement from Molina.

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

Molina Healthcare
PO Box 22815
Long Beach, CA 90801

Claims for reimbursement of Covered Services while You are traveling outside the United States must be verified by Molina before payment can be made. Molina will calculate the allowed amount that will be covered for Urgent Care Services and Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws.

Because these services are performed by a Non-Participating Provider, You will only be reimbursed for the allowed amount. The allowed amount may be less than the amount You were charged by the Non-Participating Provider. You will not be entitled to reimbursement for charges for health care services or treatment that are not covered under this EOC, specifically those identified in the "Services Provided Outside the United States (or Service Area)" in the "Exclusions" section of this EOC.

EXCLUSIONS

What Is Excluded from Coverage Under My Plan?

This "Exclusions" section lists items and services that are not covered under this EOC. These exclusions apply to all services that would otherwise be covered under this EOC regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Acupuncture Services

Acupuncture services are not covered.

Artificial Insemination and Conception by Artificial Means

All services related to artificial insemination and conception by artificial means are not covered, 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 (These are surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum. The jejunum is the section of the small intestine extending from the duodenum.)
- Gastroplasty (surgical procedures that decrease the size of the stomach)
- Gastric banding procedures

Complications directly related to bariatric surgery that result in an inpatient stay or an extended inpatient stay for the bariatric surgery, as determined by Molina, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this product or any previous Molina product. This exclusion also applies if the surgery was performed while the Member was covered by a previous carrier or self-funded product 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 are not covered when they are:

- Required for obtaining or maintaining employment or participation in employee programs;
- Required for insurance or licensing; or
- 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 or for coverage that must be provided as required under Section 609.65, Wisconsin Statutes, as amended, for a person examined, evaluated, or treated for a nervous or mental disorder pursuant to an emergency detention, a commitment, or a court order.

Cosmetic Services

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

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section.

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

The following reconstructive surgery services are not covered:

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

Custodial Care

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

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

Dental and Orthodontic Services

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

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

Dietician Services

Services of a dietician are not covered.

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 are not covered.

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

Erectile Dysfunction Drugs

Erectile dysfunction drugs are not covered unless required by applicable state law.

Experimental or Investigational Services

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

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

Please refer to the "Grievances (Internal Appeals) and External Appeals" section for information regarding denied requests for Experimental or Investigational services.

Eyeglasses and Contact Lenses for Adults

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Hair Loss or Growth Treatment

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

Infertility Services

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

Intermediate Care

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

Items and Services That Are Not Health Care Items and Services

Molina 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

Items and services (such as eye surgery or contact lenses to reshape the eye) to correct refractive defects of the eye such as myopia, hyperopia, or astigmatism are not covered. This exclusion does not apply to those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan?" section.

Male Contraceptives

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

Massage Therapy

Massage therapy is not covered.

Oral Nutrition

Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food is not covered.

Private Duty Nursing

Private duty nursing services are not covered.

Residential Care

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

- A hospital;
- A skilled nursing facility;
- An inpatient respite care covered in the "Hospice Care" section;
- A licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section; or
- A licensed facility providing transitional residential recovery services covered under the "Substance Abuse Services" section.

Routine Foot Care Items and Services

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

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

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 are not covered. This exclusion applies to services provided anywhere, even outside the U.S.

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

Please refer to the "Grievances (Internal Appeals) and External Appeals" section for information regarding denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People

We do not cover services that are performed by people who are not required to obtain licenses or certificates by the State of Wisconsin to provide health care services. We also do not cover services performed when the Member's condition does not require that a licensed health care provider provide the services. This exclusion does not apply to Qualified Autism Service Paraprofessionals or as otherwise provided in this EOC.

Services Provided Outside the United States (or Service Area)

Any services and supplies provided to a Member outside the United States or outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area. Only Emergency Services and Urgent Care Services are Covered Services outside the United States or outside the Service Area, as described in the section titled

"Covered Services Furnished While Traveling Outside the Service Area (Including the United States)".

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

Services Related to a Non-Covered Service

When a service is not covered, all services related to the non-Covered Service are not covered. This exclusion does not apply to services Molina would otherwise cover to treat complications of the non-Covered Service. For example, if You have a non-covered 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 We would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Member who is a surrogate, are not covered. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Transgender Surgery

Transgender surgeries are not covered.

Travel and Lodging Expenses

Travel and lodging expenses are not covered.

THIRD PARTY LIABILITY

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

- Reimburse Molina for the reasonable cost of services paid by Molina, to the extent permitted under Wisconsin law, immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and

- Fully cooperate with Molina's effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under Wisconsin law Molina's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

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

WORKERS' COMPENSATION

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

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

RENEWAL AND TERMINATION

How Does My Molina Coverage Renew?

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

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage

Any change to this Agreement, including, but not limited to, changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina.

When Will My Molina Membership End? (Termination of Benefits and Coverage)

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, 2016, Your last minute of coverage is at 11:59 p.m. on June 30, 2016. 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 after the termination date 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 You believe that this Agreement has been or will be improperly cancelled, rescinded or not renewed, You may file a grievance with Molina in accordance with the grievance procedures outlined in the "Grievances (Internal Appeals) and External Appeals" section below. You can find additional information regarding grievances on Our website at **www.molinahealthcare.com/marketplace**. Please contact Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 847-1778

Or, You may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
P.O. BOX 7873
MADISON, WISCONSIN 53707-7873.

You may also call **1 (800) 236-8517** outside Madison or **1 (608) 266-0103** in Madison to request a complaint form. Deaf, hearing, or speech-impaired callers may reach the **OFFICE OF THE COMMISSIONER OF INSURANCE** by dialing **7-1-1** (TTY) and asking for **1 (608) 266-3586**. You also may direct electronic mail to: **ocicomplaints@wisconsin.gov**.

Your membership with Molina will terminate if You:

- **No Longer Meet Eligibility Requirements:** Coverage under this Agreement will terminate if You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina or the Marketplace. The Marketplace will send You notice of any eligibility determination. Molina will send You notice of termination when it learns You are no longer eligible for coverage under this Agreement..
    - **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 Member with Child-Only Coverage Reaching the Limiting Age,** that Member's Child-Only Coverage under this Agreement, will terminate at 11:59 p.m. on the last day of the calendar year in which the Member reaches the limiting age of 21. When Child-Only Coverage under this Agreement terminates because the Member has reached age 21, the Member may be eligible to enroll in other products offered by Molina through the Marketplace.

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

- **Change Marketplace Health Plans**: You decide to change from Molina Healthcare to another health plan offered through the Marketplace either:

  - During an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Marketplace's special enrollment procedures; or
  - When You seek to enroll a new Dependent

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

- **Commit Fraud or Intentionally Misrepresent Material Fact:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina. Some examples include:

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

  We will send a notice of termination to You, and Your membership will end at 11:59 p.m. on the seventh day from the date We mail the notice of termination.

If Molina terminates Your membership for cause, You will 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 health benefits for new or existing health care services under this product. In this case, Molina will provide You with written notice at least 180 days prior to discontinuation of those contracts.

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

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

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

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums

Your Premium payment obligations are as follows:

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

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

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

- 10-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit. Molina will process payment for Covered Services received during the 10-day grace period. You will be responsible for any unpaid Premiums You owe Molina 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.

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

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

Reinstatement After Termination for Non-Payment of Premiums

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

- If Molina terminates this Agreement for non-payment of Premiums, We will permit reinstatement of this Agreement once during any 12-month period if We receive the amounts owed within 15 days of the date of the Termination Notice, described below. Molina will not reinstate this Agreement if You do not obtain reinstatement of Your terminated Agreement within the required 15 days, or if We terminate the Agreement for non-payment of Premiums more than once in a 12-month period.

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

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 by Molina in accordance with the grievance procedures below. You can find additional information regarding grievances on Our website at: **www.molinahealthcare.com/marketplace**. Please contact Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 847-1778

You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
P.O. BOX 7873
MADISON, WI 53707-7873

You may also call **1 (800) 236-8517** outside Madison or **1 (608) 266-0103** in Madison to request a complaint form. Deaf, hearing, or speech-impaired callers may reach the **OFFICE OF THE COMMISSIONER OF INSURANCE** by dialing **7-1-1** (TTY) and asking for **1 (608) 266-3586**.

YOUR RIGHTS AND RESPONSIBILITIES

What Are My Rights and Responsibilities as a Molina Member?

The rights and responsibilities below are also on the Molina Healthcare website: www.molinahealthcare.com/marketplace.

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 PCP).
- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina or Your care. You can call, fax, e-mail or write to 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 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 applicable state laws.
- Receive instructions on how You can view online, or request a copy of, Molina's non-proprietary clinical and administrative policies and procedures.
- Get a copy of Molina's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.
- Not to be treated poorly by Molina or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if You believe 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 Molina toll-free at **1 (888) 560-2043**.
  - If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.
- Give to Your doctor, provider, or Molina information 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 upon with Your doctor(s).
- Build and keep a strong patient-doctor relationship.
  - Cooperate with Your doctor and staff.
  - Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare ID card when getting medical care.
  - Do not give Your ID card to others.
  - Let Molina know about any fraud or wrongdoing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active in Your Health Care

Plan Ahead

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

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs
- 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) 560-2043**, Monday through Friday, between 8:00 a.m. and 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

MOLINA HEALTHCARE SERVICES

Molina Is Always Improving Services

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

If You would like to learn more about what We are doing to improve, please call Molina toll-free at **1 (888) 560-2043** for more information. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

Member Participation Committee

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

The Committee is a group of people just like You that meets once every three months and tells Us how to improve. The Committee can review health plan information and make suggestions to Molina's Board of Directors. If You want to join the Member Participation Committee, please call Molina toll-free at **1 (888) 560-2043**, Monday through Friday, 8:00 a.m. to 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service. Join Our Member Participation Committee today!

Your Health Care 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 is always looking for ways to take better care of Our Members. That is why Molina has a process to find new medical technology, drugs, and devices for possible added benefits.

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

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

What Do I Have to Pay For?

Please refer to the Benefits and Coverage Guide at the front of this EOC for Your Cost Sharing responsibilities for Covered Services.

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

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

If Molina fails to pay a Participating Provider for giving You Covered Services, You are not responsible for paying the Participating Provider for any amounts owed by Us. This is not true for Non-Participating Providers.

What if I Have Paid a Medical Bill or Prescription? (Reimbursement Provisions)

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

You will need to mail or fax Us a copy of the bill from the doctor, hospital or pharmacy and a copy of Your receipt. If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227
1 (888) 560-2043
Fax: 1 (414) 847-1778
www.molinahealthcare.com/marketplace

If You are deaf or hard of hearing You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

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 toll-free at **1 (888) 560-2043**, Monday through Friday, 8:00 a.m. to 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

How Does Molina Healthcare Pay for My Care?

Molina contracts with providers in many ways. Some Molina Participating Providers receive a flat amount for each month that You are under their care, whether You see the provider or not. Some providers work on a fee-for-service basis. This means that they receive payment for each procedure they perform. Some providers receive incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization.

For more information about how providers are paid, please call Molina's Customer Support Center toll-free at **1 (888) 560-2043**, Monday through Friday, 8:00 a.m. to 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service. You may also call Your provider's office or Your provider's medical group for this information.

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 to get information regarding State law on Advance Directives, and changes to Advance Directive laws. Molina updates Advanced Directive information no later than 90 calendar days after receiving notice of changes to State laws.

For more information, call Molina's Customer Support Center toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, dial **7-1-1** for the Telecommunications Relay Service.

Interpreter Services
Do You Speak a Language Other Than English?

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

Molina offers telephonic and interpreter services to help You with:

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

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina's Customer Support Center at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

Cultural and Linguistic Services

Molina can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina's Customer Support Center at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

COORDINATION OF BENEFITS

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

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

Definitions (applicable to this COB provision)

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

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

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

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

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

as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

2. If a person is covered by 2 or more Plans that compute their benefit payments 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.

3. 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.

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

   However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different 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.

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

"**Closed Panel Plan**" is a Plan that provides health care benefits to Members primarily in the form

of services through a panel of providers 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 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.

Coordination Disputes

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaints" section below. If You are still not satisfied, You may call the Office of the Commissioner of Insurance for instructions on filing a consumer complaint. Call **1 (800) 236-8517** (outside Madison), **1 (608) 266-0103** (in Madison), or **7-1-1** (TTY) and ask for **1 (608) 266-3586** to request a complaint form. The Complaint Form is also available at **oci.wi.gov**.

COMPLAINTS

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 toll-free at **1 (888) 560-2043**, Monday through Friday, 8:00 a.m. to 5:00 p.m. CT. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

- You may also send Us Your problem or complaint in writing by mail. Our address is:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
2400 South 102nd Street
West Allis, WI 53227

You can find additional information regarding grievances on Our website at: www.molinahealthcare.com/marketplace.

- You may resolve Your problems by taking the steps outlined in the "Grievances (Internal Appeals) and External Appeals" section below. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
P.O. BOX 7873
MADISON, WISCONSIN 53707-7873

- You may also call **1 (800) 236-8517** (outside Madison) or **1 (608) 266-0103** (in Madison) or **7-1-1** (TTY) and ask for **1 (608) 266-3586** to request a complaint form. The Complaint Form is also available at **oci.wi.gov**.

GRIEVANCES (INTERNAL APPEALS) AND EXTERNAL APPEALS

Definitions for This "Grievance (Internal Appeals) and External Appeals" Section

"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;
- 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 Participating Providers, where You are not liable for such services or charges, are not Adverse Benefit Determinations.

"Authorized Representative" means an individual authorized by You, in accordance with the provisions of this "Grievances (Internal Appeals) and External Appeals" section, to act on Your behalf with respect to a Grievance or external appeal.

"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, then the internal appeal will be deemed to be a Final Adverse Benefit Determination.

"Grievance" means any dissatisfaction with Molina that is expressed in writing to Molina by You, or Your Authorized Representative, including, but not limited to, any of the following:

- Adverse Benefit Determination;
- Provision of Covered Services;
- Determination to reform this Agreement;

- Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; or

- Claims practices.

"Grievance Panel" means a group of people responsible for the investigation of each Grievance.

"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.

"Expedited Grievance" means a Grievance where the standard resolution process may include any of the following:

- Serious jeopardy to Your life or health (or the life or health of Your unborn child) or Your ability to regain maximum function; 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 Grievance; or

- Is determined to be an expedited Grievance by the treating physician.

Filing a Grievance

1. You or Your Authorized Representative may submit the signed Grievance and any supporting materials to the Grievance Panel using one of the following methods:

By mail:
Molina Healthcare of Wisconsin, Inc.
Attn: Grievance Coordinator
2400 South 102nd Street
West Allis, WI 53227

By phone:
1 (888) 560-2043
TTY 7-1-1

By fax:
Fax: 1 (414) 847-1778

You can find additional information regarding Grievances on Our website at: **www.molinahealthcare.com/marketplace**.

Molina will acknowledge receipt of the Grievance in writing within five business days of receiving it. If Your Authorized Representative filed the Grievance on Your behalf, We will also provide a notice that health care information or medical records may be disclosed only if permitted by law. We will also include an informed consent form.

2. Molina will notify You and Your Authorized Representative (if applicable) in writing of the time and place of the Grievance Panel meeting at least seven calendar days in advance. You or Your Authorized Representative have the right to appear before the Grievance Panel in person or by telephone to present written or oral information concerning the Grievance. You may also submit written questions to the persons responsible for making the determination that resulted in the denial or determination of benefits or a decision to disenroll You.

3. Except if Your Grievance is an Expedited Grievance as described in paragraph 4 below, Molina will notify You of the disposition of the Grievance within 30 calendar days of receipt, unless Molina is not able to resolve the Grievance within 30 calendar days. In the event Molina is unable to make a determination within the initial 30 calendar days of receipt of Your Grievance, Molina may extend the determination period for an additional 30 calendar days. If an extension is required, We will notify You in writing:

   a. That Molina has not resolved the Grievance;
   b. Of the reasons for the extension; and
   c. When resolution may be expected.

4. If a Grievance involves an Expedited Grievance, Molina will resolve such Grievance within 72 hours after receipt. You may request an Expedited Grievance by calling Us at **1-888-560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service. You may fax Your request to: **1 (414) 847-1778**. You can find additional information regarding Grievances on Our website at **www.molinahealthcare.com/marketplace**.

5. You may review Molina's claim file without charge, including any new or additional evidence or rationale considered, relied upon or generated by Molina in connection with the claim.

6. Molina will require a written expression of authorization for representation from any person acting on Your behalf unless any of the following applies:

   - The person acting on Your behalf is authorized by law to act on Your behalf;

   - You are unable to give consent and the person acting on Your behalf is a spouse, family member or the treating provider; or

   - The Grievance is an Expedited Grievance and the person acting on Your behalf represents that You have verbally given him/her authorization to represent You.

   Molina shall process a Grievance without requiring written authorization unless We, in Our acknowledgement of receipt of a Grievance to the Authorized Representative, clearly and prominently do all of the following:

   - Notify the person acting on Your behalf that, unless any of the exceptions listed above apply, the Grievance will not be processed until We receive a written authorization.

   - Request written authorization from the person acting on Your behalf.

- Provide the person acting on Your behalf a form You may use to give written authorization. You may, but are not required to, use Our form to give written authorization. Molina will accept a written expression of authorization in any form, language or format.

Filing a Complaint With the Office of the Commissioner of Insurance

You may resolve Your problem by taking the steps outlined above. You may also file a complaint with the Wisconsin **OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**. The **OCI** is a state agency that enforces Wisconsin's insurance laws. You may contact the **OCI** by writing to:

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
P. O. Box 7873
Madison, WI 53707-7873

You may also call the **OCI** Complaints Department at **1 (800) 236-8517** (outside Madison), **1 (608) 266-0103** (in Madison), or **7-1-1** (TTY) and ask for **1 (608) 266-3586** to request a Complaint Form. The Complaint Form is also available at **oci.wi.gov.**

Filing an External Appeal

After You have exhausted the Grievance (internal appeal) rights provided by Molina, You have the right to request an external/independent review of an Adverse Benefit Determination. You (or Your Authorized Representative) may file a written request for an external review. Your notice of Adverse Benefit Determination and/or Final Adverse Benefit Determination describes the process to follow if You wish to pursue an external appeal.

You must submit Your request for external review within four months of the date You receive the notice of Adverse Benefit Determination or Final Adverse Benefit Determination.

You can request an external appeal by fax at **1 (888) 866-6190,** online at www.externalappeal.com, or by mail at:

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

If You have any questions or concerns during the external appeal process, You (or Your Authorized Representative) can call the toll-free number **1 (888) 866-6205**. You (or Your Authorized Representative) can submit additional written comments to the external reviewer at the mailing address above. If any additional information is submitted, it will be shared with Molina in order to give Us an opportunity to reconsider the denial.

Request for expedited external appeal – You (or Your Authorized Representative) may make a written or oral request for an expedited external appeal with the external reviewer when You receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an Expedited Grievance would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an Expedited Grievance; or

- A Final Adverse Benefit Determination, if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

- An Adverse Benefit Determination that relates to Experimental or Investigational treatment, if the treating physician certified that the recommended or requested health care service, supply, or treatment would be significantly less effective if not promptly initiated.

In expedited external appeal situations, requests for expedited review can be initiated by calling MAXIMUS Federal Services toll free at **1 (888) 866-6205**, or by faxing the request to **1 (888) 866-6190**, or by mailing the request to:

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

Additionally, at Your request, Molina can send You copies of the actual benefit provision, and will provide a copy at no charge, of the actual benefit, clinical guidelines or clinical criteria used to make the determination upon receipt of Your request. A request can be made by calling the Molina Complaints and Appeals Coordinator.

General Rules and Information

General rules regarding Molina's Complaints, Grievances (Internal Appeals) and External Appeals Process include the following:

- Molina will offer to speak 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 directly to You so You have an opportunity to review the claim file.

BINDING ARBITRATION: OPTION TO RESOLVE ALL DISPUTES, INCLUDING FUTURE MALPRACTICE CLAIMS BY BINDING ARBITRATION

Important Information About Your Rights

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

Member and Molina Healthcare agree that, by choosing to arbitrate, Member and Molina Healthcare are each waiving the right to a trial by jury or to participate in a class action. In choosing binding arbitration, Member and Molina Healthcare will be giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of final and binding arbitration in accordance with the American Arbitration Association (AAA) Commercial Arbitration Rules and Mediation Procedures, and administration of the arbitration shall be performed by the AAA or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

If Member agrees to submit a dispute to binding arbitration under this provision, Member further agrees to the following:

- The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the AAA Commercial Arbitration Rules and Mediation Procedures will be utilized.

- The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing.

- Civil discovery may be taken in such arbitration in accordance with the Wisconsin Arbitration Act.

- The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Wisconsin state law court, including, but not limited to, the imposition of sanctions.

- The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law. The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision.

- Member's agreement to submit claims to binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The parties shall divide equally the costs and expenses of the AAA and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of AAA and the

arbitrator, provided the Member submits a hardship application to the AAA. The hardship application shall be made in a manner and with the information and any documentation as required by the AAA. The AAA (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

IF YOU DECIDE TO ARBITRATE YOUR CLAIM(S) IT IS FURTHER UNDERSTOOD THAT THE PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

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 Providers shall provide or attempt to provide Benefits and Coverage insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina nor any Participating Provider shall have any liability or obligation for delay or failure to provide Benefits and Coverage if such delay or failure is the result of any of the circumstances described above.

Waiver

Molina'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 a pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

If You think You have not been treated fairly please call the Customer Support Center toll-free at **1 (888) 560-2043**. If You are deaf or hard of hearing, You may contact Us by dialing **7-1-1** for the Telecommunications Relay Service.

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 Wisconsin Department of Health Services by going online at http://www.dhs.wisconsin.gov/health/donatelife/ to add Your name to the registry.

Agreement Binding on Members

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

Assignment

You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Our prior written consent.

Governing Law

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

Invalidity

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

Notices

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

HEALTH MANAGEMENT & HEALTH MANAGEMENT LEVEL 1 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 healthy. You may ask for booklets on topics such as:

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

You can also enroll in any of the programs above by calling the Molina Health Management Department at **1 (866) 891-2320**, between 10:30 a.m. and 7:30 p.m. CT, Monday through Friday.

Motherhood Matters®

A Prenatal Care Program for Pregnant Women

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

Motherhood Matters® is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. We will mail You a pregnancy book that You can use as a reference throughout Your pregnancy.

You will be able to talk with Our caring staff about any questions You may have during Your pregnancy. They will teach You what You need to do. If any problems are found, a nurse will

work closely with You and Your doctor to help You. Being a part of this program and following the guidelines can help You have a healthy pregnancy and a healthy baby.

Your Baby's Good Health Begins When You Are Pregnant

You learn:

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

Other benefits include:

- Health Education materials, including a pregnancy book
- Referrals to community resources available for pregnant women

To find out more about the Motherhood Matters® program, call the Molina Health Management Department at **1 (866) 891-2320** between 10:30 a.m. and 7:30 p.m. CT, Monday through Friday.

Diabetes Self-Management Training

We cover diabetes self-management training programs designed to help individuals learn to manage their diabetes in an outpatient setting. For information on Diabetes Self-Management Training, call **1 (888) 999-2404** between 8:00 a.m. and 5:00 p.m. CT, Monday through Friday.

HEALTH MANAGEMENT LEVEL 1 PROGRAMS

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 10:30 a.m. and 7:30 p.m. CT, Monday through Friday. Ask about other services We provide, or request information to be mailed to You.

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

Smoking Cessation Program

This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support. You will also be given a telephone number that You can call anytime You need help.

Weight Control Program

This program is for Members who need help controlling their weight. The weight control program is provided for Members age 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program.

Your Health Care Quick Reference Guide

Department/Program	Type of Help Needed	Contact Information
Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina's services, We want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 a.m. to 5:00 p.m. CT. When in doubt, call Us first.	**Customer Support Center Toll Free:1 (888) 560-2043** Fax: 1 (414) 847-1778 TTY: 7-1-1 for the Telecommunications Relay Service
Health Management	To request information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	1 (866) 891-2320 10:30 a.m. to 7:30 p.m. CT, Monday through Friday
Health Management Level 1 Programs	To request information on smoking cessation and weight management.	1 (866)-472-9483 10:30 a.m. to 7:30 p.m. CT, Monday through Friday
Nurse Advice Line 24-hours a day, seven days a week	If You have questions or concerns about Your health or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 Spanish: 1 (866) 648-3537 English TTY 1 (866) 735-2929 Spanish TTY 1 (866) 833-4703
Motherhood Matters®	Molina offers a special program called Motherhood Matters® to Our pregnant members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (866) 891-2320 10:30 a.m. to 7:30 p.m. CT, Monday through Friday
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 (415) 437-8310 TTY: 1 (415) 437-8311 Fax: 1 (415) 437-8329
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for health care, but does not cover all medical expenses.	1 (800) MEDICARE 1 (800) 633-4227 TTY: 1 (877) 486-2048 www.Medicare.gov
Wisconsin Office of the Commissioner of Insurance	The Wisconsin Office of the Commissioner of Insurance is responsible for regulating health maintenance organizations. If You have a grievance against Molina, You should first call Molina Customer Support Center toll-free at **1 (888) 560-2043**, and use Molina's grievance process before contacting the Office of the Commissioner of Insurance.	www.oci.wi.gov 1 (800) 236-8517 (outside Madison) or 1 (608) 266-0103 (in Madison) or TTY 7-1-1, ask for 1 (608) 266-3586.

2400 South 102nd Street
West Allis, WI 53227

Product offered by Molina Healthcare of Wisconsin, Inc.,
a wholly owned subsidiary of Molina Healthcare, Inc.