2020
Molina Healthcare of Wisconsin, Inc. Agreement and Individual Evidence of Coverage

Marketplace

Wisconsin

11002 W. Park Place
Milwaukee, WI 53224

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.

MolinaMarketplace.com

MOLINA HEALTHCARE

Your Extended Family.

Non-Discrimination Notification
Molina Healthcare

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، المجانًا، لك. تتصل بخدمات الأعضاء. يوجد الرقم على الجزء الخلفي من بطاقة هويتك. (Arabic)

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

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

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

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

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

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

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

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

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

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេង ដូចជា ទម្រង់ជាសម្លេង អក្សរស្ទាប ទំហំអក្សរធំដោយសារតែតម្រូវការជាពិសេសរបស់អ្នក ឬជាភាសារបស់អ្នកដោយមិនគិតតម្លៃបន្ថែមឡើយ។ (Cambodian)

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 Covered Services as described in this Agreement.

This Agreement, amendments to this Agreement, the applicable Schedule of Benefits for this product, and any application(s) submitted to the Marketplace and/or Molina 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
11002 W. Park Place
Milwaukee, WI 53224
1 (888) 560-2043
MolinaMarketplace.com

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.

If You move from the address You had when You enrolled with Molina or if You change phone numbers, contact the Marketplace at 1 (800) 318-2596.

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 MolinaMarketplace.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
11002 W. Park Place
Milwaukee, WI 53224
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 214-2489

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
11002 W. Park Place
Milwaukee, WI 53224
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.

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

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

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

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

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

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

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

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

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

Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family.

"**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 Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible and/or Copayment.

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

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

"**Covered Service"** or **"Covered Services**" refers to the healthcare services, including supplies and prescription drugs, that You are entitled to receive from Molina under this agreement.

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

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

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

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

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in: 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. Experimental or Investigational services are not covered; however, this exclusion does not apply to treatments mandated by Wisconsin or Federal law. This exclusion does not apply to

services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan?" section. Experimental or Investigational services require Prior Authorization from Our Chief Medical Officer.

"**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 Doctor**" (also a "**Primary Care Physician**" and "**Personal Doctor**") who has identified their primary professional designation to Us as a "PCP", and is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to a Specialist Physician for other services. A Primary Care Doctor includes, but is not limited to, 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 see adults and children 14 years or older.
- Pediatrician, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

"**Primary Care Provider**" ("PCP") means:

- Primary Care Doctor, or
- An individual practice association (IPA) or group of licensed doctors who have identified their primary professional designation to Us as Primary Care, which provides primary care services through the Primary Care Doctor, or
- Other Practitioner who within the scope of his or her license is authorized to provide primary care services.

"Prior Authorization" means Molina's prior determination for Medical Necessity of Covered Services, including certain prescription medications, before services are provided. Prior Authorization is not a guarantee of payment for services. Payment is made based upon the following;

- benefit limitations

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

"**Rehabilitative Services**" means health care services that help You keep, get back, or improve skills and functioning for daily living that have been lost or impaired because You were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

"**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, who has entered into a contract and who has identified their primary professional designation to Us as other than a "PCP", to deliver Covered Services to Members..

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this EOC, the term "Spouse" includes the Subscriber's same-sex spouse.

"**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.

"Telehealth and Telemedicine Services" means:

- Delivery of Covered Services by a Participating Provider through audio and video conferencing technology that permits communication between a Member at an originating site and a Participating Provider at a distant site, allowing for the diagnosis or treatment of Covered Services.

- The communication does not involve in-person contact between the Member and a Participating Provider. During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.

Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Requirement: When using "Store and Forward" technology, all covered services must also include an in-person office visit to determine diagnosis or treatment.

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

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?

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 the Marketplace and/or Molina.

For coverage during the calendar year 2020, the initial open enrollment period begins November 1, 2019 and ends December 15, 2019. Your Effective Date for coverage during 2019 will depend on when You applied:

- If You applied on or before December 15, 2019, the Effective Date of Your coverage is January 1, 2020.
- Applications made after December 15, 2019 are subject to Special Enrollment Period requirements and verification

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

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

Who Is Eligible?

To enroll and stay enrolled You must meet all of the eligibility requirements. 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 Covered Services)."

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.

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.

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

Age Limit for Children (Children with Disabilities): 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.

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 the Marketplace and/or Molina and submit any required application(s), forms and requested information for the Dependent.

Requests to enroll a new Dependent must be submitted to the Marketplace and/or Molina 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;
    - 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, 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.

  Please note: claims for newborns will be processed as part of the mother's claims and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first 31 days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum.

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

- **Court Order 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 Covered Services: Except under Child-Only Coverage, Covered Services for Your Dependent will be discontinued on:

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

You get a Member identification card (ID card) from Molina Healthcare. We will issue an ID card within 10 business days after You make your first payment. 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, you can get a temporary ID card at mymolina.com, and you can get a new ID card by calling 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.

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 also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- 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.MolinaMarketplace.com**. Here You can view Our online list of Participating Providers.

In general, the first person You should call for any healthcare is Your PCP; however, You may visit another Participating Provider instead of Your PCP, and a referral is not required.

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 in any emergency room. Except for Emergency Services, and as otherwise noted in this document, 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.

Telehealth and Telemedicine Services
You may obtain Covered Services that are provided through telehealth, except as specifically stated in this agreement. In-person contact between You and the doctor is not required for these services, and the type of setting where these services are provided is not limited. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Member cost sharing is shown in Your Schedule of Benefits.
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment. Please refer to the "Definition" section for explanation.

The following 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. **English [1 (888) 275-8750],** *TTY [1 (866) 735-2929]* **Spanish [1 (866) 648-3537],** *TTY [1 (866) 833-4703]*
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as pregnancy tests, birth control, sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization 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 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 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 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 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:MolinaMarketplace.com. You do not need a Prior Authorization or referral.
To go to the hospital	If You need Emergency Services or 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. **English: [1 (888) 275-8750],** *TTY: [1 (866) 735-2929]* **Spanish: [1 (866) 648-3537],** *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?
A Primary Care Provider (or PCP) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

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

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

If You want to know more about Your PCP or other Molina Healthcare doctors, call Us. Molina's Customer Support Center number is toll-free at 1 (888) 295-7651.

Choosing Your Doctor (Choice of Physician and Providers)

For Your health care to be covered under this product, Your health care services must be provided by Molina Healthcare Participating Providers. This includes doctors, hospitals, Specialist Physicians, urgent care clinics or medical clinics. The exception is Emergency Services. 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.MolinaMarketplace.com] 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. For more information, 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 make a request to change Your PCP at any time. The effective date of the change will be based on whether You are asking for a change to a PCP with whom You already have an appointment scheduled, or whether You are asking for a future change. Below are the PCP change effective dates, depending on the type of request You are making:

- You have an appointment already scheduled: the effective date is the date of the notification.
- You are requesting a future PCP change: the change will be effective on the second day of the following month.

But first, visit your doctor. Get to know Your PCP before changing. Having a good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina Healthcare doctor.

Can My Doctor Request That I Change to a Different 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.MolinaMarketplace.com**. 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
11002 W. Park Place
Milwaukee, WI 53224
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 214-2489
MolinaMarketplace.com

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 Molina included a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) on the Molina provider directory and represented that the provider was, or would be, a Participating Provider in marketing materials that were provided or available at the time of Your enrollment, Molina will make the physician available to You and cover services provided by the physician at in-network Cost Sharing for the entire plan year.

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

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

An "Active Course of Treatment" is:

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

A "Life-Threatening Condition" is:

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

A "Serious Acute Condition" is

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

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

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

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition. Unless otherwise required by law, Molina will reimburse the provider up to the previously contracted amount for such service. You may be responsible to the provider for any billed amounts

that exceed the amount paid by Molina under this section. That would be in addition to any in-network Cost-Sharing amounts that You owe under this EOC. In addition, any payment for the amounts that exceed the previously contracted amount will not be applied to Your Deductible or Your Annual Out-of-Pocket Maximum.

Transition of Care

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

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

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

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

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

What If There Is No Participating Provider to Provide a Covered Service?

If there is no Participating Provider that can provide a non-Emergency Covered Service, We will provide the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the same Covered Services when rendered by Participating Providers, provided You obtain prior authorization before the initiation of the service. In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

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

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

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:

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

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

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

- All inpatient admissions (except hospice)
- Certain Ambulatory Surgery Center service (ASC)*
- Certain drugs as indicated on the Molina Drug Formulary*
- Certain Durable Medical Equipment*
- Certain injectable drugs and medications not listed on the Molina Drug Formulary*
- Mental Health Services
  - Day treatment
  - Electroconvulsive Therapy (ECT)
  - Mental health inpatient
  - Neuropsychological and psychological testing
  - Partial hospitalization
  - Behavioral health treatment for PDD/autism
- Certain outpatient hospital service*
- Colonoscopy for Members under age 50
- Cosmetic, plastic, and reconstructive procedures
- Custom orthotics, prosthetics, and braces. Examples are:
  - Any kind of wheelchairs (manual or electric)
  - Internally implanted hearing device
  - Scooters
  - Shoes or shoe supports
  - Special braces
- Drug quantities that exceed the day-supply limit
- Experimental or Investigational procedures
- Formulary Specialty (Oral and Injectable) drugs
- Gene Therapy (Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.
- Genetic counseling and testing
- Home healthcare and home infusion therapy (after 7 visits for home settings)
- Hyperbaric therapy
- Imaging and special tests. Examples are:
  - CT (Computed Tomography)
  - MRI (Magnetic Resonance Imaging)
  - MRA (Magnetic Resonance Angiogram)
  - PET (Positron Emission Tomography) scan
- Low vision follow-up care
- Medically Necessary genetic testing
- Occupational Therapy (after initial evaluation and 12 visits/year for outpatient and home settings)
- Pain management care and procedures, except trigger point injections
- Physical Therapy (after initial evaluation and 12 visits/year for outpatient and home settings)
- Radiation therapy and radiosurgery
- Speech Therapy (after 7 visits for outpatient and home settings)
- Services rendered by a Non-Participating Provider
- Sleep studies (except home sleep studies)

- Substance Abuse Services:
  - Inpatient services
  - Day Treatment
  - Detoxification Services
  - Partial hospitalization
- Transplant evaluation and related services including Solid Organ and Bone Marrow (Cornea transplant does not require Prior Authorization)
- Transportation (Non-Emergency Air Ambulance)
- Unlisted and miscellaneous medical codes or 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.

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

Approvals are given based on Medical Necessity. You or Your Participating Provider may call for Prior Authorization; however, You are ultimately responsible for requesting the Prior Authorization. If You have questions about how a certain service is approved, call Molina 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.

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.

Molina will respond to the Prior Authorization request within 14 calendar days from the receipt of the request. Routine Prior Authorization requests will be processed within five business days of getting complete information. 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. We will deny a Prior Authorization if information We request is not provided to Us.

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.

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 **MolinaMarketplace.com** to find a Participating Provider for a second opinion. We only cover second opinions when furnished by a Participating Provider.

Here are some, but not all, 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.

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, after getting 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 Emergency Services are covered.

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

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits . You must get Urgent Care Services from a Participating Provider. 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 go to the nearest emergency room.

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Please be aware that You must get services from a Participating Provider, otherwise You will be 100% responsible for payment and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum for any of these services.

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 for treatment of an Emergency Medical condition are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Schedule of Benefits.

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

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

Because Non-Participating Providers are not in Molina's contracted provider network, they may balance-bill You for the difference between Our allowed amount, described above, and the rate that they charge. You will be responsible for charges that exceed the allowed amount covered under this benefit.

Mandatory Transfer to a Participating Provider Hospital

You must have a Prior Authorization to get hospital services, except in the case of Emergency Services. If You get services in a hospital or You are admitted to the hospital for Emergency Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

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

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

- Medically Necessary
- Prior Authorized
- A Covered Service

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

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

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.

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.

COVERED SERVICES

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 , 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 Schedule of Benefits.

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 Schedule of Benefits. 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 SCHEDULE OF BENEFITS CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

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

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

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

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

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

family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family.

Coinsurance

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

Deductible

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

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

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

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

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

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

General Rules Applicable to Cost Sharing

All Covered Services have a Cost Sharing, unless specifically stated or until You pay the applicable Annual Out-of-Pocket Maximum. Please refer to the Schedule of Benefits. 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. If You receive a bill for services, and You believe the bill to be incorrect, please contact your Provider to discuss Your concerns, If, after talking to Your Provider's office, You still have concerns about the amount You owe, please contact our Member Services department at the number shown on Your Molina identification card.

Please note: You are responsible for paying charges for any health care services or treatments that are not Covered Services under this EOC. This may include charges for any health care services provided by Non-Participating Providers (such as, but not limited to, emergency room providers, radiologists, anesthesiologists, or pathologists). This may include any Non-Participating Provider who is delivering services in a Participating Provider hospital.

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 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 YourCovered 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 for Participating Provider 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. . Members are responsible for 100% of charges for services furnished by a Non-participating provider. Please consult with your PCP to determine whether a specific service is preventive or diagnostic, as not all procedures are preventive. You do not pay any Cost Sharing for:

- Alcohol and Drug Use assessments for adolescents
- All comprehensive perinatal services are covered. These include perinatal and postpartum

care, health education, nutrition assessment and psychological services.

- Autism screening for children 18-24 months
- Basic vision screening (non-refractive)

Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)

- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections.
- Cervical dysplasia screening for sexually active females
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder
- 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.
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management
- Hearing Screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- Hearing screening for newborns
- HIV screening for adolescents at higher risk
- Immunizations*****
- Iron supplementation in children when prescribed by a PCP
- Lead blood level testing. (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral health risk assessment for young children (ages 0-10) (1 visit per 6-month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

*****If You take Your child to Your local health department, or the school has given Your child any

shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

Preventive Services for Adults and Seniors

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

- Abdominal aortic aneurysm screening (for male former smokers age 65 – 75)
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA screening, counseling about breast cancer prevention medication
- Breast cancer and chemoprevention counseling for women at high risk
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies, counseling
- Cancer screening
- Chlamydial infection screening: women
- Cholesterol check
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) for women every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology
- Cytologic screening in a hospital or certified lab for the presence of cervical cancer
- Depression screening: adults
- Depression screening: Postpartum women
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling: adults at higher risk for chronic disease
- Dietary evaluation and nutritional counseling
- Exercise to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls

- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Healthy diet counseling
- Hearing screenings
- Hepatitis B screening: pregnant women
- High blood pressure screening
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: adults
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention
- Prostate specific antigen testing
- Rh incompatibility screening: 24-28 weeks gestation
- Rh incompatibility screening: first pregnancy visit
- Scheduled prenatal care exams and postpartum follow-up consultations and exams
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Screening for osteoporosis for women age 65 years and older
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Statin preventive medication: adults ages 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions
    - Screening for tobacco use; and,
    - For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

- Tuberculosis (TB) screening
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

PHYSICIAN SERVICES

We cover the following outpatient physician services:

- Consultations and well-child care
- Injections, allergy tests and treatments
- 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
- Physician care in or out of the hospital
- Prevention, diagnosis, and treatment of illness or injury
- Routine examinations and prenatal care provided by an OB/GYN to female Members
- Routine pediatric and adult health exams
- Specialist Physician (for example, a heart doctor or cancer doctor) consultations
- Telemedicine Visits
  - Visit must be medically necessary
  - Must be associated with an office visit
  - Electronic mail (e-mail) by a Practitioner/Provider or consultation by telephone for which a charge is made to the patient is not covered
- Visits to the doctor's office

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:

- Cardiac rehabilitation therapy (36-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.
- Physical Therapy (20-visit limit per calendar year).
- Post-cochlear implant aural therapy (30-visit limit per calendar year).
- Pulmonary rehabilitation therapy (20-visit limit per calendar year).

- Speech Therapy (20-visit limit per calendar year). This does not include services described under the "Autism Spectrum Disorders Services" section.

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
- Outpatient services for monitoring drug therapy
- Psychological testing when necessary to evaluate a Mental Disorder (defined below)

We cover outpatient mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the 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
- Claims that have been determined by Us to be fraudulent
- 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
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Therapy, treatment, or services provided to a Member who is residing in a residential treatment center, inpatient treatment facility, or day treatment facility

- 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
- Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Qualified Therapists, or Qualified Paraprofessionals

OUTPATIENT SUBSTANCE ABUSE SERVICES

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

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

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

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;
- 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 Schedule of Benefits.

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

VISION SERVICES

We cover the following vision services for all Members:

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

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

ADULT ROUTINE VISION SERVICES

We cover the following vision services for Members age 19 and older, when provided by a participating VSP Provider. Refer to your Schedule of Benefits for applicability of coverage under your plan.

- Comprehensive vision exam limited to one every calendar year.
- Routine retinal screening (copay applies).
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every calendar year.
- Covered frames include a limited selection of frames at no cost, up to $150. Additional frames may be selected by you. Additional costs will apply.
- Prescription glass or plastic lenses: include single vision, lined bifocal, lined trifocal or lenticular lenses.
- Prescription contact lenses: limited to one year supply, up to $150, every calendar year, in lieu of prescription lenses and frames; includes evaluation, fitting and follow-up care.
- Contact lenses in lieu of glasses.

Laser corrective surgery is not covered.

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 calendar year
  - 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.

DIABETES SERVICES

We cover the following diabetes-related services:

- Diabetes education
- Diabetic eye examinations (dilated retinal examinations)
- Medical nutrition therapy services
- Outpatient self-management training, as described in the section of this Agreement titled, "Health Management"
- Routine foot care for Members with diabetes

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:

- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Emergency birth control supplies when filled by a Participating Provider pharmacist, or by a Non-Participating Provider in the event of an Emergency
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Limited history and physical examination
- Pregnancy testing and counseling
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Screening, testing and counseling of at-risk individuals for HIV and referral for treatment
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- 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. Prior Authorization is required. Molina will help you select an appropriate facility.

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

We cover radiology services, other than specialized scanning services. Except for Emergency Services. You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum.

CHEMOTHERAPY

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

LABORATORY TESTS

We cover the services listed below when Medically Necessary. These services are subject to Cost Sharing. Except for Emergency Services, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to Your Deductible or Annual Out-of-Pocket Maximum.

- Blood and blood plasma

- Laboratory tests
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- 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:

- Psychiatric observation for an acute psychiatric crisis
- 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

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services, except in the case of an Emergency or Participating Provider 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 and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

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

If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

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:

- Anesthesia
- Blood, blood products and their administration
- 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 the “What is Covered Under My Plan?” section)
- Durable Medical Equipment and medical supplies
- General and special nursing care

- Imaging, laboratory and special procedures, including MRI, CT and PET scans
- Mastectomies (removal of breast) and lymph node dissections
- Medical social services and discharge planning
- Operating and recovery rooms
- Physical, occupational and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program), limited to 60 days per year combined for all therapies
- Radioactive materials used for therapeutic purposes
- Respiratory therapy
- Room and board, including a private room if Medically Necessary
- Services of Participating Provider physicians, including consultation and treatment by Specialist Physicians
- Specialized care and critical care units

CHEMOTHERAPY

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

MATERNITY CARE

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 Schedule of Benefits for the Cost Sharing that will apply to these services.
- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48- or 96-hour period, Molina 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.

Involuntary inpatient mental health and behavioral health admissions do not require Prior Authorization. Involuntary inpatient mental health and behavioral services beyond 72 hours will be covered only if deemed Medically Necessary by Molina's Medical Director or designee and available in a Participating Provider hospital.

We cover inpatient mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the 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:

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

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
- Counseling services for You and Your family
- Development of a care plan for You
- Dietician services
- Drugs
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Nursing care
- Pain control
- 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
- Physician services
- 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
- Short-term inpatient care
- Symptom management

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. You may discuss the options with Your provider. No Prior Authorization is required.

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 Schedule of Benefits.

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

Reconstructive Surgery Exclusions

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery 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 evaluation, organ removal, direct follow-up care, 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 Schedule of Benefits.

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

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications when:

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

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

Please note, Cost Sharing for any prescription brand name drugs with a generic equivalent obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third party Cost-Sharing assistance, will not apply toward any Deductible, or the Annual Out-of-Pocket Maximum under Your Plan.

We cover:

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

We cover drugs when they are on the Drug Formulary. We cover drugs when obtained through Molina's Participating Provider pharmacies within the Service Area. Non-formulary drugs may be covered only as provided in the "Access to Drugs Which Are Not Covered" section below. Prescription drugs are covered outside the Service Area for Emergency Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Our Customer Support Center toll-free at 1 (888) 560-2043 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (888) 665-4629 or contact Us with the Telecommunications Relay Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 560-2043. You may view a list of pharmacies on Molina Healthcare's website MolinaMarketplace.com.

Molina Healthcare Drug Formulary (List of Drugs)

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

The group meets every 3 months to talk about the drugs that are in the Drug Formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added to or removed from the Drug Formulary based on changes in medical

practice and medical technology. They may also be added to the Drug Formulary when new drugs come on the market.

Some of the reasons You may not be approved are:

- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Over-the-Counter drugs not on the formulary
- Drugs not FDA approved or licensed for use in the United States

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

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

You can look at Our Drug Formulary on Our Molina Healthcare website at MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 560-2043, Monday through Friday, 8:00 a.m. through 5:00 p.m. ET. If You are deaf or hard of hearing, call toll-free 1 (888) 665-4629 or dial 711 for the Telecommunications Relay Service.

You can also ask Us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Cost Sharing for Prescription Drugs and Medications

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

Tier-1: Preferred Generic Drugs

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

Preferred generic drugs are those drugs listed that, due to clinical effectiveness and cost differences, are designated as “Tier-1” in the Molina Drug Formulary.

Tier-2 Preferred Generic and Brand Name Drugs

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

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

Tier-3 Non-Preferred Brand and Generic Drugs

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

Tier-4 Brand and Generic Specialty Drugs

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

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

- Are only approved to treat limited patient populations, indications or conditions, including but not limited to growth hormone injections and drugs for treatment of infertility; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies; or
- A biosimilar, a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product.

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

We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications. The maximum Cost Share for an orally administered anti-cancer medication is $100 for up to a 30 day supply and is not subject to a deductible.

Tier-5 Preventive Drugs

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

Opioid Analgesics Prescribed for Chronic Pain
If you are prescribed opioid analgesics for chronic pain, Prior Authorization may be required prior to

receiving opioid analgesics for chronic pain, except under the following circumstances:

- Opioid analgesics prescribed to a Member who is a hospice patient in a hospice care program;
- Opioid analgesics prescribed to a Member who has been diagnosed with a terminal condition, but is not a hospice patient in a hospice care program; or
- Opioid analgesics prescribed to a Member who is actively being treated for cancer.

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.

Access to Drugs That Are Not Covered

Molina has a process to allow You to request and gain access to clinically appropriate drugs that are not covered under Your product.

Molina Healthcare may cover specific non-formulary drugs when the prescriber documents in Your medical record and certifies that the Drug Formulary alternative has been ineffective in the treatment of the Member's disease or condition, or the Drug Formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

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

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

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

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

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

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

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

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

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

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

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

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

Over-the-Counter Preventive Drugs and Supplements

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

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

Off Label Drugs

We cover drugs approved by the United States Food and Drug Administration for treatment of indications for which the drug has not been approved by the United States Food and Drug Administration, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the U.S. Department of Health and Human Services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature where all of the following apply:

(1) Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;

(2) No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;

(3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the U.S. Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395 (x)(t)(2)(B), as amended, as accepted peer-reviewed medical literature.

Stop-Smoking Drugs

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

Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop-smoking medication.

Mail Order Availability of Formulary Prescription Drugs

Molina offers You a mail order Formulary Prescription drug option. This option applies only to prescription drug tiers 1, 2, 3 and 5. Formulary Prescription drugs can be mailed to You within 10 days from order request and approval. Cost Sharing is for up to a 90-day supply is two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one month.

You may request mail order service in the following ways:

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

Cancer Drug Therapy

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

Diabetic Supplies

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

Day Supply Limit

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

up to a 90-day supply for Mail Order.

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT

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

Covered DME includes (but is not limited to):

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

We cover the following DME and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind;
- Insulin pumps and all related necessary supplies, 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. However, braces that stabilize an injured body part and braces to treat curvature of the spine are covered.

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 Schedule of Benefits 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:

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

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 seven (7) visits for outpatient and home settings.

TRANSPORTATION SERVICES

Emergency Medical Transportation

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

Non-Emergency Medical Transportation

We cover non-routine, non-Emergency Medically Necessary ground transportation, when Molina determines such transportation is needed within Our Service Area to transfer You from one medical facility to another. Examples of this are from one hospital to another hospital, from a hospital to a skilled nursing facility or hospice. Non-Emergency medical transportation is provided by wheelchair lift equipped vehicle, litter/stretcher van or non-Emergency ambulance (both advanced life support and basic life support). When non-Emergency medical transportation is needed, Molina will arrange for the transportation to be provided by one of our Participating Provider transportation vendors. Please note, this is not a service for which you can self-refer and any services not arranged by Molina will not be covered.

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.

Covered Services for hearing services are limited to one hearing aid per ear every three years.

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 Emergency Services while traveling outside of the Service Area. This includes travel that takes You outside of the United States. 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 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 for weight loss 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

A service of a dietician is not a covered benefit. This exclusion does not apply to services under "Hospice Care".

Disposable Supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, and other incontinence supplies 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. This exclusion does not apply to treatments mandated by Wisconsin or Federal law.

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.

Gene Therapy

Most gene therapy is not covered. Molina covers limited gene therapy in accordance with our medical policies, subject to Prior Authorization.

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 treatment of infertility are not covered. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

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:

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

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 "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;
- 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;
- A licensed facility providing transitional residential recovery services covered under the "Substance Abuse Services" section; or.
- A skilled nursing facility.

Routine Foot Care Items and Services

Routine foot care items and services that are not Medically Necessary are not covered, except for persons diagnosed with diabetes.

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

Sexual Dysfunction

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

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.

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 Covered Services

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

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

The termination date of Your coverage is the first day You are not covered with Molina. For example, if Your termination date is July 1, 2020, Your last minute of coverage is at 11:59 p.m. on June 30, 2020. 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 **MolinaMarketplace.com**. Please contact Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
PO Box 242480
Milwaukee, WI 53224-9931

1 (888) 560-2043
TTY [7-1-1
Fax: 1 (414) 214-2489

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.

  - **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 the Marketplace (1-800-318-2596) and/or Molina. 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.

- **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 in the individual market. In this case, Molina will provide You with written notice at least 180 days prior to the date the coverage will be discontinued.

- **Withdrawal of Product:** Molina withdraws Your product from the market. In this case, Molina will provide You with written notice at least 90 days prior to the date the coverage will be discontinued.

- **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 Covered Services 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 Vision Services covered under this Agreement; and as a result, such Member's coverage under those specific Covered Services 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

If permitted by the Marketplace, We will allow reinstatement of Your Agreement (without a break in coverage) provided the reinstatement is a correction of an erroneous termination or cancellation action.

Re-enrollment After Termination for Non-Payment

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

Termination for Non-Payment 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: **MolinaMarketplace.com**. Please contact Molina's Customer Support Center at:

Molina Healthcare of Wisconsin, Inc.
Customer Support Center
11002 W. Park Place
Milwaukee, WI 53224
1 (888) 560-2043
TTY 7-1-1
Fax: 1 (414) 214-2489

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**. You may e-mail them at: **ocicomplaints@wisconsin.gov**.

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: MolinaMarketplace.com.

Your Rights

You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina.
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina's list of Participating Providers (This doctor is called Your 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 Schedule of Benefits 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 , 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? ()

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. You should also include the name of the Member for whom you are submitting the claim and Your policy number. 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
11002 W. Park Place
Milwaukee, WI 53224
1 (888) 560-2043

Fax: 1 (414) 214-2489
MolinaMarketplace.com

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 request for reimbursement, We will respond to You within 30 days. If Your claim is accepted, We will mail You a check. If Your claim is denied, We will send You a letter telling You why. If You do not agree with this, You may file an 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 provider can answer questions about Advance Directives.

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**. You also may send an e-mail to:**ocicomplaints@wisconsin.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
11002 W. Park Place
Milwaukee, WI 53224

You can find additional information regarding grievances on Our website at: MolinaMarketplace.com.

- 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**. You may e-mail them at: **ocicomplaints@wisconsin.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
   11002 W. Park Place
   Milwaukee, WI 53224
   By fax:
   Fax: 1 (844) 251-1445

   You can find additional information regarding Grievances on Our website at: MolinaMarketplace.com.

   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: 1-844-251-1445. You can find additional information regarding Grievances on Our website at **MolinaMarketplace.com**.

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.** You may e-mail them at: **ocicomplaints@wisconsin.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.

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 Covered Services 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 Covered Services if such delay or failure is the result of any of the circumstances described above.

Waiver

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

Non-Discrimination

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

If You think You have not been treated fairly please call the Customer Support Center toll-free at **1 (888) 560-2043**. 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 reporting any change in address by contacting [the Marketplace] at [1 (800) 318-2596].

Wellness Programs

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

Annual Health Activity

We encourage You to complete the annual health activity below, during the calendar year. Upon completion, Molina may work with You to support Your overall wellness.

Annual Wellness Exam

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

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

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

You can get information or join any of the programs above by calling the Molina Health Management Department at 1 (866) 891-2320 10:30 a.m. and 5:30 p.m. (CT), Monday through Friday. You may also call us if you wish to stop receiving program materials.

Newsletters

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

Health Education Materials

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

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) 214-2489] TTY: [7-1-1] for the Telecommunications Relay Service
Health Education	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 5:30 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]
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]. [ocicomplaints@wisconsin.gov]