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

Molina Marketplace Ohio
PO Box 349020, Columbus, Ohio 43234-9020

The following are required notices:

NOTICE: SUBSCRIBER HAS THE RIGHT TO RESCIND THIS MOLINA HEALTHCARE OF OHIO, INC. AGREEMENT AND INDIVIDUAL EVIDENCE OF COVERAGE (THE "AGREEMENT") UNTIL MIDNIGHT OF THE TENTH DAY AFTER THE DATE HE OR SHE RECEIVED THIS AGREEMENT. IF SUBSCRIBER RESCINDS THE AGREEMENT DURING THAT PERIOD, WE WILL CHARGE THE SUBSCRIBER PREMIUM FOR THE NUMBER OF DAYS THAT THE AGREEMENT WAS IN EFFECT. THIS RIGHT TO RESCIND ENDS IF ANY MEMBER MAKES A CLAIM FOR BENEFITS OR RECEIVES COVERED SERVICES BEFORE THE RIGHT TO RESCIND IS EXERCISED.
TO RESCIND THIS POLICY, RETURN THIS AGREEMENT TO:

MOLINA HEALTHCARE OF OHIO, INC.
PO BOX 349020
COLUMBUS, OHIO 43234-9020

PLEASE TELL US YOUR NAME AND THAT YOU WANT TO RESCIND THE AGREEMENT, ALTHOUGH YOU DO NOT NEED TO TELL US WHY.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

MEDICARE ADVISORY
This certificate is not a Medicare supplement certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

MolinaMarketplace.com
Service Area: Counties of Ashtabula, Athens, Butler, Champaign, Clark, Clermont, Coshocton, Crawford, Cuyahoga, Erie, Fairfield, Fayette, Franklin, Greene, Hamilton, Hancock, Highland, Holmes, Huron, Lake, Lawrence, Licking, Lorain, Lucas, Madison, Mahoning, Montgomery, Muskingum, Pickaway, Pike, Richland, Ross, Scioto, Stark, Trumbull, Warren, Wood, Wyandot

Contents

This Molina Healthcare of Ohio, Inc. Agreement and Individual Evidence of Coverage (also called the "**EOC**" or "**Agreement**") is issued by Molina Healthcare of Ohio, 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 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 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 Agreement tells You what services You can get.

Molina is an Ohio licensed Health Insuring Corporation.

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

Molina Healthcare of Ohio, Inc.
Customer Support Center
PO Box 349020
Columbus, Ohio 43234-9020
1 (888) 296-7677
MolinaMarketplace.com

If You are deaf or hard of hearing You may contact Us through Our dedicated TTY line, toll-free, at 1 (800) 750-0750 or by dialing 711 for the Telecommunications Relay Service.

This (policy or certificate) is not a Medicare supplement (policy or certificate). If You are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Molina.

INTRODUCTION

Thank You for choosing Molina as Your health plan.

This document is Your "Molina Healthcare of Ohio, Inc. Agreement and Individual Evidence of Coverage" (Your "Agreement"). The Agreement tells You how You can get services through Molina. It sets out the terms and conditions of coverage under this product. It sets out Your rights and responsibilities as a Molina Member and describes how to contact Molina. Please read this Agreement completely and carefully. Keep it in a safe place where You can get to it quickly. If You have special health care needs, carefully read the sections that apply to You.

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 benefits.

Call Us toll-free at 1 (888) 296-7677. Call between 7:00 a.m. to 7:00 p.m. ET Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line. The toll-free number is 1 (800) 750-0750. You can also dial 711 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.

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. We want 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.

Why does Molina 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 purposes not listed above.

What are Your privacy rights?

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

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

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

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice of Privacy Practices is in the following section of this Agreement. It is on Our web site at MolinaMarketplace.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center. The number is 1(888) 296-7677.

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF OHIO, INC.

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

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

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

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

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

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

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

When can Molina 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 purposes including the following:

Required by law
We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the 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 a purpose other than those listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given Us. Your cancellation will not apply to actions already taken by Us because of the approval You already gave to Us.

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

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

- **Request Confidential Communications of PHI**
  You may ask Molina 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's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by Us. This may include records used in making coverage, claims and other decisions as a Molina 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 disagreeing with Us if We deny the request.

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

  - For treatment, payment or health care operations;
  - To persons about their own PHI;
  - Sharing done with Your authorization;
  - Incident to a use or disclosure otherwise permitted or required under applicable law;
  - 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, or may get a paper copy of this Notice. Please call Our Customer Support Center at 1(888) 296-7677.

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
PO Box 349020
Columbus, Ohio 43234-9020
1 (888) 296-7677

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, Illinois 60601
1 (800) 368-1019; 1 (800) 537-7697 (TDD)
1 (312) 886-1807 (FAX)

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 Your PHI;
- Provide You with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change
Molina 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
PO Box 349020
Columbus, Ohio 43234-9020
Phone: 1 (888) 296-7677

DEFINITIONS

Some of the words used in this Agreement 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 Agreement, We explain what it means in that section. Words with special meaning used in any section of this Agreement are explained in this "Definitions" section and are capitalized throughout this Agreement.

"**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. It includes the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"Annual Maximum Out-of-Pocket" (also referred to as **"MOOP**") is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The MOOP 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 MOOP.

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

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

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual MOOP 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 MOOP 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 has agreed to 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 at the beginning of this Agreement.

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

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina 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 has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Agreement.

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 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.

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in the "Eligibility and Enrollment" section of this Agreement.

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

"**Durable Medical Equipment**" or "**DME**" is medical equipment that serves a repeated medical purpose and serves for repeated use. DME is generally not useful to You if You are not ill or injured and does not include accessories primarily for Your comfort or convenience. Examples include, without limitation:

- oxygen equipment,
- blood glucose monitors,
- apnea monitors,
- nebulizer machines,
- insulin pumps,
- wheelchairs and crutches.

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- placing the health of the Member (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

"**Emergency Service**s" 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 offered by Molina to You and/or Your Dependents, as defined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services. Includes behavioral health treatment
- Prescription drugs
- Rehabilitative and Habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services. Includes dental***** and vision care for a Member until 11:59 p.m. on the last day of the month that the Member turns age 19

*****Pediatric dental services are not covered under this Agreement. These dental services can be purchased separately through a stand-alone dental product that is certified by the Marketplace. Molina will help You sign up for a stand-alone pediatric dental product, or You may purchase pediatric dental on the Marketplace by calling 1-800-318-2596 or by visiting healthcare.gov.

"**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.

"**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 Ohio buy qualified health plan coverage from insurance companies or health plans such as Molina. The Marketplace may be run as a state-based marketplace, a federally facilitated marketplace, or a partnership marketplace. For the purposes of this Agreement, the term refers to the Marketplace operating in the State of Ohio, 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;
- 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 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 based on credible scientific evidence published in peer-reviewed medical literature. This literature is 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 Agreement, "You" and "Your" may be used to refer to a Member or Subscriber, as the context requires.

"**Molina Healthcare of Ohio, Inc. (**also "**Molina Healthcare**" or "**Molina**" or "**We**" or "**Our**" or "**Us**"**)**" means the corporation licensed in the State of Ohio as a Health Insurance Corporation, and contracted with the Marketplace.

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

"**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.

"**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.

"**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.

"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.

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

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

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

"**Subscriber**" means either:

- An individual who is a resident of Ohio, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina 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 Member under this Agreement.

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

"Telehealth and **Telemedicine"** Services means:

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

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

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

"**Urgent care services**" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

ELIGIBILITY AND ENROLLMENT

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

For coverage during the calendar year 2020, the initial open enrollment period begins November 1, 2019 and ends December 15, 2019. Your Effective Date for coverage during 2020 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 60 days from qualifying event. 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 continue enrollment, You must meet all of the eligibility requirements established by the Marketplace. Check the Marketplace's website at healthcare.gov for eligibility criteria. Molina requires the Subscriber to live in Molina's 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, as described in the section titled "When Will My Molina Membership End? (Termination of Covered Services)," You will not be permitted to re-enroll.

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 in this product during the open enrollment period established by the Marketplace may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Molina requires Dependents to meet all applicable participation requirements under state and federal law to be eligible to enroll under this product. The following types of family members are 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
  - His or her Spouse's children
  - 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).
- Subscriber's grandchildren do not qualify as Dependents of the Subscriber unless the Subscriber or Subscriber's spouse is a legal guardian or as otherwise required by law.

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 the limiting age of 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 because 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 for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

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

You must submit requests to enroll a new Dependent to the Marketplace and/or Molina within 60 days from the date the Dependent became eligible to enroll with Molina.

- **Spouse:** You can add a Spouse as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:
  - The Spouse loses "minimum essential coverage" through:
    - Government sponsored programs;
    - Employer-sponsored plans;
    - Individual market plans; or
    - Any other coverage designated as "minimum essential coverage" in compliance under 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 26, including a stepchild, except in Child-Only Coverage, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:
  - The child loses "minimum essential coverage" through:
    - Government sponsored programs;
    - Employer-sponsored plans;
    - Individual market plans; or
    - Any other coverage designated as "minimum essential coverage" as defined 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.

- **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 from the date of birth. Notify Molina within 60 days of any birth or adoption for enrollment. Additional premium will be charged up to a maximum of three dependents under the age of 21.

  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)" above for more information.
- The date the Dependent Spouse enters a final decree of divorce, annulment, or dissolution of marriage from the Subscriber.
- For Child-Only Coverage, the date You are no longer eligible.

MEMBER IDENTIFICATION (ID) CARD

You get a Member identification card (ID card) from Molina. 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 request a new ID card at mymolina.com or by calling Molina toll-free at **1 (888) 296- 7677**. We will be happy to send You a new card.

For information on how to obtain health care services, call Molina's Customer Support Center toll-free at 1 (888) 296-7677. Or call Our 24-Hour Nurse Advice Line at 1 (888) 275-8750.

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 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 for Spanish speaking Members
- Toll free number for prescription related questions.
- The identifier for Molina's prescription drug benefit
- Toll free number for hospitals to notify Molina of admissions for Our Members
- Toll free number for emergency rooms to notify Molina of emergency room admissions for Our Members

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

ACCESSING CARE

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

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

Molina Marketplace Provider Network: Your plan includes the "Molina Marketplace" network of Participating Providers. For additional information or questions about the provider network, call 1 (888) 296-7677 or visit MolinaMarketplace.com.

Molina's Provider Directory includes a list of the PCP and hospitals that are available to You as a Molina Member. You may visit Molina's website at MolinaMarketplace.com to 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. For more information about which facilities are with Molina or where they are located, call Molina toll-free at **1 (888) 296-7677**. You may get Emergency Services in any emergency room, wherever located.

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

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

Telehealth and Telemedicine Services
You may obtain Covered Services 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 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.

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

ALWAYS CONSULT YOUR PCP FIRST. HOWEVER, REFERRALS ARE NOT REQUIRED FOR YOU TO ACCESS SPECIALISTS OR OTHER PRACTITIONER CARE.	
TYPE OF HELP YOU NEED:	**WHERE TO GO. WHOM TO CALL.**
Emergency Services	Call **911** or go to the nearest emergency room. Even when outside Molina's network or Service Area, please call **911** or go to the nearest emergency room for Emergency Services.
Urgent Care Services	You may also call Your PCP or Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor)	Women may go to any Participating Provider OB/GYN without a referral or Prior Authorization. Ask Your doctor or call Molina's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a mental health or substance abuse Participating Provider. You do not need a referral or Prior Authorization to get a mental health or substance abuse evaluation.
For mental health or substance abuse therapy	Go to a mental/behavioral 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, get help as directed under "Emergency Services" or "Urgent Care Services" above.
To get a second opinion	Consult Molina's Provider Directory on Our website at MolinaMarketplace.com to find a Participating Provider for a second opinion. You do not need a Prior Authorization or referral.

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. WHOM TO CALL.**
To go to the Hospital	If You need Emergency Services, get help as directed under "Emergency Services". 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 Nurse Advice Line. • Toll-free 1 (888) 275-8750 • Spanish 1 (866) 648-3537

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

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

If You want to know more about Your PCP or other Molina doctors, call Us. Molina's Customer Support Center toll-free number is 1 (888) 296-7677.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this product, Your health care services must be provided by Molina Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of 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 listing of doctors and hospitals that are available under this Agreement. You will also learn some helpful tips on how to use the services and benefits covered under this Agreement. Your Provider Directory can be found on Our website at MolinaMarketplace.com under Find A Doctor or Pharmacy. If You have questions about the Provider Directory, please call Us. Our toll-free number is 1 (888) 296-7677.

In Molina's Provider Directory You can find:

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

You can also find out whether a Participating Provider is accepting new patients.

Note: Some hospitals and providers may not provide some of the services that may be covered under this Agreement that You or Your family member might need. This includes family planning, birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should get more information before You enroll.

Call Your doctor, medical group, or clinic. Or call the Customer Support Center toll-free at 1 (888) 296-7677 to make sure that You can get the health care services that You need.

How Do I Choose a PCP?
It is easy to choose a PCP. Simply use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for Yourself and another one for Your family members.

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 Us. Our toll free number is 1 (888) 296-7677. We can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina doctor.

What if I Do Not Choose a PCP?
Molina asks that You select a PCP within 30 days of joining Molina. However, if You do not choose a PCP, Molina will choose one for You.

CHANGING YOUR DOCTOR

What if I Want to Change my PCP?
You can change Your PCP at any time.

- All changes completed by the 25th of the month will be in effect on the first day of the following calendar month.
- Any changes on or after the 26th of the month will be in effect on the first day of the second calendar month.

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 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 Doctor breaks down.

How do I Change My PCP?
Call Molina toll-free at 1 (888) 296-7677. Call Monday through Friday, 7:00 a.m. to 7:00 p.m. ET. You may also visit Molina's website at MolinaMarketplace.com. Here You can view Our online list of doctors. Let Us help You make the change.

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

- The PCP is no longer a Participating Provider with Molina.
- 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?
If Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina, 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, You can choose a different doctor. Our Molina Customer Support Center staff can help You make a choice.

If Molina is ending its contractual relationship with a PCP or hospital, then Molina will provide the Member written notice within 30-days after the contract ending between Molina and:

- a PCP if the Member has received health care services from the PCP within the previous 12 months or if the Member selected the PCP within the previous 12 months; and
- a hospital if the Member received health care services within the previous 12 months.

Molina will mail the notice to the Subscriber at the Subscriber's last known address. Molina will pay for all Covered Services rendered to a Member by a PCP or hospital from the end of the provider contract through five days after the notification of the contract termination is mailed to the Subscriber at the Subscriber's last known address.

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

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

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

A "Life-Threatening Condition" is:
- a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

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

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

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

We will provide Covered Services at in-network Cost Sharing for the specifically requested medical condition. 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 Covered Service, You may request Prior Authorization to obtain 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. This means there will be no balance billing, and Molina will cover out-of-network preventive services at no charge if there is no qualified in-network provider. In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

Please contact Us toll-free at **1 (888) 296-7677** between 7:00 a.m. to 7:00 p.m. ET Monday through Friday. If You are deaf or hard of hearing, You may contact Us through Our dedicated TTY line. The toll-free number is **1 (800) 750-0750**. You may also dial 711 for the Telecommunications Relay Service for more information.

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

What is a Prior Authorization?

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

You do not need Prior Authorization for the following services:

- Dialysis (One time notification is requested; Prior Authorization is not required; please notify Molina before services are rendered by calling 1(888) 296-7677)
- 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
  - Occupational therapy
  - Physical therapy
- Services for sexually transmitted diseases
- Urgent Care services

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

- All inpatient admissions (except hospice)
- Approved clinical trials
- Certain Ambulatory Surgery Center service (ASC)*
- Certain drugs as follows
  - as indicated on the published Drug Formulary*
  - Certain injectable drugs and medications not listed on the Molina Drug Formulary*
  - Formulary Specialty (Oral and Injectable) drugs
  - Opioid Analgesics as described in the section titled "Opioid Analgesics Opioid Analgesics Prescribed for Chronic Pain"
- Certain Durable Medical Equipment*
- 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
- Genetic counseling and testing
- Gene therapy (Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.)
- 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
- Pain management care and procedures, except trigger point injections
- Radiation therapy and radio surgery
- 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 Ground and Air Ambulance)
- Any other services listed as requiring Prior Authorization in this EOC

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

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."

For a chronic condition, Molina will honor a Prior Authorization of an approved drug for 12 months, as long as the Member continues to be eligible for benefits under the plan.

Approvals are given based on Medical Necessity. You or Your Participating Provider may call for Prior Authorization.

*If You have questions about how a certain service is approved, call Molina toll-free at **1 (888) 296-7677**. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at **1 (800) 750-0750**. You may dial 711 for the Telecommunications Relay Service.

We will be happy to send You a general explanation of how certain Prior Authorization decisions are made.

Request Types	Time Frame for Adverse Decision	Time Frame for Notification of Adverse Decision
Prospective Review Determination	Within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	Within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
Concurrent Review Determination	24 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	24 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
Retrospective Review Determination	30 days from the receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	30 days from the receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)

Please Note: Additional information requests for Urgent Care Services will be made within 24 hours in accordance with state law.

Medical conditions that may cause a serious threat to Your health are processed as timely as is possible given the circumstances. They will always be processed within no more than 72 hours (except in the case of Urgent Care approval that will be completed within 24 hours) from receipt of all information reasonably necessary and requested by Molina to make the determination. Or, if shorter, they will be processed within the period required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. We will deny a Prior Authorization if information We request is not provided to Us.

We may request information from You or Your provider in order to make the decision. A Prior Authorization may be denied because information We request is not provided

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

The denial letter will tell You how to appeal. These instructions are also noted in the section of this Agreement titled "Claims Decisions, Internal Appeals, and External Review."

If Molina authorizes a proposed admission, treatment, or health care service by a Participating Provider based upon the complete and accurate submission of all necessary information relative to an eligible enrollee, then Molina shall not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with Molina.

Reconsideration
Your Participating Provider may request a reconsideration of a denial of a Routine or Concurrent Determination on Your behalf. The Participating Provider may not request reconsideration without Your prior consent. The reconsideration will occur within three business days after We receive a written request for reconsideration.

You do not need to request a reconsideration of a denial prior to registering a complaint or requesting a review in the manner described in the Complaints section of this Agreement.

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

If Your condition or disease is life threatening, worsening, or disabling, You may need to receive a standing approval to a specialty care center with 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 specialists to ensure You receive a treatment plan based on Your medical needs. We will make a determination regarding standing approval within three business days from after We receive all information reasonably necessary and requested by Molina.

If You have any difficulty getting a standing approval, call Molina toll-free at 1 (888) 296-7677. Our dedicated TTY for the deaf or hard of hearing is toll-free at 1 (800) 750-0750. You may dial 711 for the Telecommunications Relay Service.

If after calling Molina You feel Your needs have not been met, please refer to Molina's complaint process, which is described in the section of this Agreement titled "Complaints."

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 Molina's Provider Directory on Our website at MolinaMarketplace.com to find a Participating Provider for a second opinion. We cover second opinions only when furnished by a Participating Provider.

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

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

EMERGENCY SERVICES AND URGENT CARE SERVICES

What is an Emergency?
Please refer to the definition section of this EOC for more information on "Emergency" or "Emergency Medical Condition".

Emergency Services also includes Emergency contraceptive drug therapy.

Services provided within an emergency room that do not meet the definition of Emergency Services are considered non-emergent and will be not covered.

How do I get Emergency Services?
Emergency Services are available 24 hours a day, seven days a week for Molina 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 Member ID card with You.

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 at 1 (888) 275-8750. For Spanish, call 1 (866) 648-3537. The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing, please use the Telecommunications Relay Service by dialing 711.

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

What if I Am Away From Molina's Service Area and I Need Emergency Services?
Go to the nearest emergency room for care.

Please contact Molina within 24 hours, or when medically reasonable, of getting Emergency Services. Call toll-free at 1 (888) 296-7677. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 750-0750.

When You are away from Molina's Service Area, only Emergency and Urgent Services are covered.

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

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

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

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Please be aware that if You go to a Non-Participating Provider, they may balance-bill you for the difference between Our allowed amount and the rate they charge. You will be responsible for charges that exceed the allowed amount covered by Us.

Emergency Services Rendered by a Non-Participating Provider
Molina covers Emergency Services obtained from Non-Participating providers in accordance with state and federal law. Emergency Services obtained for treatment of an Emergency Medical Condition, whether from Participating Providers or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Schedule of Benefits. You are not subject to balance-billing for Emergency Services.

Mandatory Transfer to a Participating Provider Hospital
If You are admitted to a Non-Participating Provider 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 the Annual Maximum Out-of-Pocket.

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 has a program that can help. The Complex Case Management program is for Members with difficult health problems that need extra help with their health care needs, which includes opioid treatment.

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

If You would like information about this program, please call the Customer Support Center toll free at 1 (888) 296-7677. Our dedicated TTY for the deaf or hard of hearing is toll-free at 1 (800) 750-0750. Or dial 711 for the Telecommunications Relay Service.

Pregnancy — What if I am pregnant?
If You think You are pregnant—or as soon as You know You are pregnant—please call a Participating Provider 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 toll-free at 1 (888) 296-7677, Monday through Friday from 7:00 a.m. to 7:00 p.m. ET. We will be happy to assist You.

Molina offers a special program called Motherhood Matters to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. For more information, call the Motherhood Matters pregnancy program toll-free at 1 (866) 891-2320, Monday through Friday, 11:30 a.m. to 8:30 p.m. ET.

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 and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access
Molina has made every effort to ensure that Our offices and the offices of Molina doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Us. Our toll-free number is 1 (888) 296-7677. Or call Our dedicated TTY line toll-free at 1 (800) 750-0750. A Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Call Molina's Customer Support Center. Our TTY Number is toll-free at 1 (800) 750-0750; or call the Telecommunications Relay Service by dialing 711.

Access for Persons with Low Vision or Who are Blind
This Agreement and other important product information will be made available in the following accessible formats for persons with low vision or who are blind:

- Braille
- Large-size print
- Enlarged computer disk format
- Audio format

For accessible formats, or for direct help in reading the Agreement and other materials, please call Molina toll-free at 1 (888) 296-7677. Members who need information in an accessible format can ask for it from Molina's Customer Support Center.

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

COVERED SERVICES

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

- You are a Member on the date that You receive the Covered Services
- The Covered Services are Medically Necessary
- The services are listed as Covered Services in this Agreement
- 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 Agreement – e.g., in the case of an Emergency Services.

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

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 at the beginning of this Agreement.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act) that are provided by Participating Providers. Cost Sharing for Covered Services is listed in the Schedule of Benefits at the beginning of this Agreement. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by the Marketplace's rules.

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

YOU SHOULD REVIEW THE SCHEDULE OF BENEFITS CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Maximum Out-of-Pocket
Also referred to as **"MOOP,"** this is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The MOOP 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 MOOP.

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

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

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual MOOP 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 MOOP 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 Co-insurance amount is calculated as a percentage of the rates that Molina has agreed to 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
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 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 has negotiated with the Participating Provider. Deductibles are listed in the Schedule of Benefits at the beginning of this Agreement.

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 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 Maximum Out-of-Pocket. Please refer to the Schedule of Benefits at the beginning of this Agreement 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:

- 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 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 that You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due.

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

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

How Your Coverage Satisfies the Affordable Care Act
Your Covered Services include Essential Health Benefits (EHB) as defined by the Affordable Care Act. If non-EHB coverage is included in Your product, those Covered Services will be set out in this Agreement 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 as of 11:59 p.m. on the last day of the month that You turn age 19. This includes pediatric dental, which can be purchased separately through the Marketplace, and pediatric vision.

The Affordable Care Act provides certain rules for EHB. These rules tell Molina how to administer certain benefits and Cost Sharing under this Agreement. 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 Agreement.

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 Maximum Out-of-Pocket that is determined under the Affordable Care Act. For the purposes of this EHB Annual Maximum Out-of-Pocket, Cost Sharing refers to any costs that a Member is required to pay to receive EHB. Such Cost Sharing includes Deductibles, Coinsurance, Copayments, 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 to reduce Your Premiums and/or Your Cost Sharing responsibility toward the EHB.
- For information about any annual limits on Cost Sharing towards Your EHB.
- To assist You in determining whether You are a qualifying American Indian or Alaskan Native who has limited or no Cost Sharing responsibilities for EHB.

Molina will work with the Marketplace in helping You. Molina does not determine or provide Affordable Care Act tax credits.

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

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

You have the right to appeal if a service is denied. For information on how You can have Your case reviewed, refer to the section of this Agreement titled "Claims Decisions, Internal Appeals, and External Review."

In general, Your care must not be Experimental or Investigational. However, You may ask for Prior Authorization 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 Agreement titled "Approved Clinical Trials."

Certain medical services described in this section will be covered by Molina only 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, go to the section of this Agreement titled "What Is a Prior Authorization." Prior Authorization does not apply to treatment of Emergency 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. Please consult with Your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for the following when provided by a Participating Provider:

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, as published on the USPSTF website at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations;
- 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 theindividual 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, preventive care services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- Scheduled prenatal care exams and first postpartum follow-up consultation exam.

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

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

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 as long as they are consistent with the Affordable Care Act and applicable Ohio 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 covered under this Agreement are listed below. In addition, You may call Our Customer Support Center toll-free at 1 (888) 296-7677, or call Our dedicated TTY line toll-free at 1 (800) 750-0750 with any questions You have about preventive care services. You may also obtain information regarding preventive care services by visiting the following website: www.healthcare.gov/center/regulations/prevention.html.

If an item or service is removed from the list of covered preventive care services below, the change will be effective after 60 days' notice to the Subscriber's address of record with Molina.

Preventive Services for Children and Adolescents
The following preventive care services are covered and recommended for children and adolescents (through age 18). You will not pay any Cost Sharing if services are furnished by a Participating Provider.

- Complete health history
- Physical exam including growth assessment
- Well baby visits and care
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Basic vision screening (non-refractive)
- Dental screening (one every six months)
- Oral health risk assessment for young children (ages 0-10) (one visit per 6-month period)
- Fluoride for children over 6 months of age without fluoride in their water source (when prescribed by a Participating Provider)
- Hearing screening for newborns
- Routine preventive hearing screenings
- Immunizations*****
- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health education
- Lead blood level testing. Parents or legal guardians of Members ages six months to 72 months are entitled to receive from their PCP; oral or written anticipatory guidance on lead exposure, This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health education, nutrition assessment, and psychological services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21, including those with special health care needs
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation (when prescribed by a Participating Provider)
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns
- Depression screening: adolescents
- Alcohol and drug use assessment: adolescents
- Autism screening – children 18 and 24 months
- Behavioral health assessment: children
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Cervical dysplasia screening: sexually active females
- Dyslipidema screening: children at higher risk of lipid disorder
- Hematocrit or hemoglobin screening: children of all ages
- HIV screening: adolescents at higher risk
- Sexually transmitted infection prevention counseling: adolescents at higher risk
- Skin cancer behavioral counseling age 10 to 24

- Tobacco use counseling: school-aged children and adolescents

*****If You take Your child to Your local health department or the school has given Your child any "shots" (immunizations), 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 adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider:

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Mammogram for women (based on Your age)
- 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.
- Pap smear for women (based on Your age) and health status including human papilloma virus
- (HPV) screening test
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- Immunizations
- Health education
- Family planning services
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation (when prescribed by a Participating Provider)
- Vitamin D supplementation (when prescribed by a Participating Provider)
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies, counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Diabetes (Type 2) screening for adults with high blood pressure
- Routine preventive hearing screenings
- Abdominal aortic aneurysm screening: for male former smokers age 65 - 75
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- BRCA screening, counseling about breast cancer preventive medication
- Chlamydial infection screening: women
- Depression screening: adults (including Postpartum women)

- Diet counseling: adults at higher risk for chronic disease
- Healthy diet counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Syphilis screening and counseling – all adults at high risk
- Gonorrhea screening and counseling – all women at high risk
- Behavioral health assessment for adults who are at increased risk for sexually transmitted infections.
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women
- Exercise to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
- Tobacco use counseling and interventions
- Well-woman visits
- Screening and counseling for interpersonal and domestic violence: women
- Breast Cancer Chemoprevention counseling for women at higher risk
- Preeclampsia prevention: aspirin
- Preeclampsia: screening
- 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

PHYSICIAN SERVICES

We cover the following outpatient physician services:

- Prevention, diagnosis, and treatment of illness or injury
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist Physician (for example, a heart doctor or cancer doctor) consultations
- Injections, allergy tests and treatments
- Physician care in or out of the hospital
- Consultations and well-child care
- Routine examinations and prenatal care provided by an OB/GYN to female Members
- Infertility services: Diagnostic and exploratory procedures to determine infertility.
    - These include surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including, but not limited to, endometriosis, collapsed/clogged fallopian tubes, or testicular failure.
- Treatment of injuries and/or diseases affecting the eye.

OUTPATIENT MATERNITY AND NEWBORN CARE

Physician-directed follow-up care including:

- Physical assessment of the mother and newborn
- Parent education
- Assistance and training in breast or bottle feeding
- Assessment of the home support system
- Performance of any Medically Necessary and appropriate clinical tests
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Outpatient maternity and newborn care includes:

- 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.

Refer to the section titled "Inpatient Maternity and Newborn Care."

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. Habilitative Services include treatment of Autism Spectrum Disorder for children ages 0-21, limits do not apply to services for Autism:

- Outpatient physical rehabilitation services including:
    - Speech and language therapy performed by a licensed therapist: 20 visits per year;
    - Occupational therapy performed by a licensed therapist: 20 visits per year; and
    - Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the State of Ohio to perform the services in accordance with a treatment plan: 20 hours per week.
- Outpatient mental health services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development, and oversight of treatment plans

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 usually requiring physical therapy, speech therapy, and occupational therapy in a setting appropriate for the level of disability or injury.

- **Physical therapy (24 visit limit per calendar year)** – Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to:

    - Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness;
    - Repetitive exercise to improve movement, maintain strength and increase endurance (includes assistance with walking for weak or unstable patients);
    - Range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities;
    - General exercise programs;
    - Diathermy, ultrasound and heat treatments for pulmonary conditions;
    - Diapulse; work hardening.

- **Speech therapy (24 visit limit per calendar year)** – Treatment for the correction of a speech impairment.

- **Occupational therapy (24 visit limit per calendar year)** Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to:

    - Supplies (looms, ceramic tiles, leather, utensils);
    - Therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again;
    - General exercises to promote overall fitness and flexibility;
    - Therapy to improve motivation;
    - Suction therapy for newborns (feeding machines);
    - Soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation),
    - Augmented soft tissue mobilization, myofascial;
    - Adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation, and other types of similar equipment.

- **Manipulation Therapy (12-visit limit per calendar year)** – Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

  Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

- **Cardiac rehabilitation (36 visit limit per calendar year)** – Treatment to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.

- **Pulmonary rehabilitation (24 visit limit per calendar year)** – Treatment to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to outpatient short-term respiratory services for conditions expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

OUTPATIENT MENTAL HEALTH SERVICES

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

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

We cover outpatient mental health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Molina covers the screening, diagnosis, and treatment of autism spectrum disorder only as provided in this Agreement under:

- "Preventive Care for Children and Adolescents" in the "Preventive Services and the Affordable Care Act" section above; and
- "Habilitative Services" section above.

OUTPATIENT SUBSTANCE ABUSE SERVICES

We cover the following outpatient care for treatment of substance abuse (which includes Opioids):

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

DENTAL AND ORTHODONTIC SERVICES

We do not cover most dental and orthodontic services. 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 authorizes 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 all of the following are true:

- You are under age 7, You are developmentally disabled, or Your health is compromised
- 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 authorizes a Non-Participating Provider who is a dentist or orthodontist to provide the services.

Dental Services Related to Accidental Injury
Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident

and the final repair. Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

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

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

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

DIABETES SERVICES

We cover the following diabetes-related services:

- Diabetic eye examinations (dilated retinal examinations)
- Routine foot care for Members with diabetes

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".

Vision Services Related to Accidental Injury or Diseases Affecting the Eye
We cover services for medical and surgical treatment of injuries and/or diseases affecting the eye. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available for glasses and contact lenses except as described in the "Prosthetics" benefit.

Covered Services include the following services:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

These additional services are not part of the preventive care benefit, and Cost Sharing will be based on the where the services are received. No additional ophthalmological services are covered except as described above.

Pediatric Vision Services
We cover the following vision services for a Member until 11:59 p.m. on the last day of the month that the Member turns age 19:

- Routine vision screening and eye exam every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of covered frames. Participating Providers will show the limited selection of covered frames available to You under this product.
- Frames that are not within the limited selection of covered frames under this product are not covered.
- Prescription Lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses, and polycarbonate lenses. Lenses include scratch resistant coating and UV protection. Additional lens options available at no charge include fashion and gradient tinting, oversized lenses and glass-grey #3 prescription sunglass lenses.
- Prescription Contact Lenses: limited to one pair of standard 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.

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. You may incur out-of-pocket expenses as a result of the purchase of vision care services or vision care materials that are not covered vision services.

- 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 a 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 in a calendar, 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.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

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, including OB/GYN Specialist Physicians, are available for family planning services. You can do this without having to get Prior Authorization from Molina. Molina pays the doctor or clinic for the family planning services You get. Family planning services include:

- Health education and counseling to help You make informed choices and to understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use.
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera.

- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's).
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers.
- Emergency birth control supplies when filled by a Participating Provider pharmacist or by a Non-Participating Provider in the event of an Emergency.
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Pregnancy testing and counseling.
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated.
- Screening, testing, and counseling of at-risk individuals for HIV, and referral for treatment.

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 performed in the 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.**

Infertility Services
We cover diagnostic and exploratory procedures to determine infertility. These include surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including, but not limited to, endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

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 (CT/PET Scans, MRIs)
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. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non- Participating Providers, and the payments will not apply to the Annual Maximum Out-of-Pocket. Refer to the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

Chemotherapy
We cover chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

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

Home Infusion Therapy
We cover home infusion therapy include a combination of nursing, durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to, injections (intra-muscular, subcutaneous, and continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.

Laboratory Tests
We cover the following services when Medically Necessary and subject to Cost Sharing. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to the Annual Maximum Out-of-Pocket. Refer to the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

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

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

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

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services, except in the case of an Emergency 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.

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 the Annual Maximum Out-of-Pocket.

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians; includes consultation and treatment by Specialist Physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines. (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drug Coverage" in this "What is Covered Under My Plan?" section)
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections
- Blood, blood products, and their administration
- 60-days of rehabilitation services including physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Infertility Services
Diagnostic and exploratory procedures to determine infertility. These include surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including, but not limited to, endometriosis, collapsed/clogged fallopian tubes, or testicular failure.

Inpatient Maternity and Newborn Care
We cover the following maternity and newborn 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 and Newborn 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 (or advanced practice registered nurse or certified Midwife authorized and licensed under Ohio Law in collaboration with a physician), after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour period, Molina will cover Physician-directed follow-up care within the first 72 hours following Your discharge. (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).
- Routine nursery care for newborns

Refer to the section titled "Outpatient Maternity and Newborn Care."

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. Participating Providers must be licensed health care professionals acting within the scope of their license. We cover inpatient mental health services only when the services are for the diagnosis or treatment of Mental Disorders.

A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The "Mental Disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "Mental Disorder."

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) "Habilitative Services" section above.

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 includes opioid – use disorder, prior authorization of opioid treatment is designated as an expedited process.

Substance Abuse Transitional Residential Recovery Services
We cover substance abuse treatment in a nonmedical transitional residential recovery setting. This treatment must be approved in writing by Molina. These settings provide counseling and support services in a structured environment. Substance Abuse includes opioid – use disorder.

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

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

You must have Prior Authorization for these services before the service begins. You will continue to get care without interruption. Services must be billed by a Skilled Nursing Facility Participating Provider.

The SNF benefit is limited to 90 days per calendar year.

Hospice Care
We cover these hospice services if You are terminally ill:

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

The hospice benefit is for Members who are diagnosed with a terminal illness and have a life expectancy of 6 months or less. You can choose hospice care instead of the traditional services covered by the plan. Please contact Molina for further information.

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

- Be enrolled for coverage in this product.
- Be diagnosed with cancer or other life threatening disease or condition.
- Be accepted into an approved clinical trial (as defined below).
- Have received Prior Authorization or approval from Molina.

For approved clinical trials involving cancer You must also provide Molina with reasonable notice of Your enrollment in the clinical trial.

For approved clinical trials involving a life-threatening disease or condition other than cancer You must also provide Molina with medical and scientific information establishing that Your participation in such trial would be appropriate based upon Your meeting the conditions described in the Affordable Care Act, which require that You be eligible to participate in the approved clinical trial according to the trial protocol with respect to the treatment of the life-threatening disease or condition.

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and that one of the following three statements is true:

1. The study is approved or funded by one or more of the following:

    a. National Institutes of Health
    b. Centers for Disease Control and Prevention
    c. Agency for Health Care Research and Quality
    d. Centers for Medicare and Medicaid Services
    e. U.S. Department of Defense
    f. U.S. Department of Veterans Affairs
    g. U.S. Department of Energy

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration;
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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 Agreement based on Your health condition or participation in a clinical trial.

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 that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service 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.

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, all stages of reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the Member.

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
Excluding those services described in the "Reconstructive Surgery" section above, the following reconstructive surgery services are not covered:

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

Transplant Services
We cover transplants of organs, tissue, or bone marrow at participating transplant facilities. These types of transplants are covered if Molina authorizes 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.
- The transplant benefit period begins one day prior to a covered transplant procedure and continues for the applicable case rate/global time period for services received at or coordinated by a transplant Participating Provider facility. The number of days will vary depending on the type of transplant received and the transplant Participating Provider agreement. Contact Molina Customer Support at 1 (888) 296-7677 for specific transplant Participating Provider information.

- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. Prior Authorized unrelated donor searches for bone marrow/stem cell transplants for a covered transplant procedure have a limit of $30,000 per transplant benefit period.
- Molina provides donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. Donor benefits are limited to benefits not available to the donor from any other source. These services must be directly related to a covered transplant for You. Included are services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Complications from the donor procedure are covered for up to six weeks from the date of procurement.

For covered transplant services, including donation-related 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.

Your coverage includes benefits related to transplant services for reasonable and necessary travel expenses You incur, including meals, transportation, and lodging. This coverage includes the transplant recipient and a family member, or two family members if the patient is under age 18.

Travel expenses are calculated based upon the reasonable and necessary amount of travel, including meals, transportation, and lodging expenses, regardless of what You actually pay. Amounts that You do not pay or that are not reasonable or necessary are not covered.

These additional benefits are available only if the Member's immediate family lives more than 75 miles from the approved transplant facility. Excluded from this transportation and lodging benefit are:

- child care;
- mileage within the transplant city;
- rental cars, buses, taxis or shuttle service, except as specifically approved;
- frequent flyer miles;
- coupons, vouchers or travel tickets;
- prepayments or deposits;
- services for a condition that is not directly related to, or a direct result of, the transplant;
- telephone calls;
- laundry;
- postage;
- entertainment;
- interim visits to a medical facility while waiting for the actual transplant procedure;
- travel expenses for donor companion/caregiver; and
- return visits for the donor for a treatment of a condition found during evaluation.

Your claims for reimbursement for reasonable and necessary travel expenses including meals, transportation, and lodging should be submitted as follows:

Molina Healthcare
PO Box 349020
Columbus, Ohio 43234-9020

Claims for reimbursement for reasonable and necessary travel expenses including meals, transportation, and lodging must be verified and approved as reasonable and necessary by Molina

before payment can be made. Molina will not reimburse You for amounts You are required to pay as Cost Sharing. Molina will reimburse only for costs associated with transplant services covered under this Agreement, less applicable Cost Sharing amounts.

You will not be entitled to reimbursement for charges for travel expenses (including meals and lodging) that are excluded from coverage under this Agreement. There is a limit of $10,000 for meals, transportation, and lodging per transplant benefit period.

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 skilled nursing facility.
- The prescription drug or medication must be ordered by a Participating Provider in connection with a Covered Service.
- The prescription drug or medication must be filled at 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 reduction 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 of the Service Area for Emergency Services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 296-7677 for assistance. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 750-0750 or contact Us with the Telecommunications Relay Service by dialing 711.

You may view a list of pharmacies on Molina'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 Your drug 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) 560-4087, 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 on the Schedule of Benefits. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, is not subject to Cost Sharing. The amount You pay is the lesser of the Cost Sharing shown in the Schedule of Benefits or the amount Molina has negotiated.

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 Brand 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. All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication. The maximum Please check your Schedule of Benefits for applicable Cost Share for an orally administered anti-cancer medication. The Cost Share associated to your plan is 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, You must obtain a Prior Authorization 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 has cancer or another condition

Please see section "Access to Drugs That have a Restriction" for information on Prior Authorization. Prior Authorization will be expedited.

For Opioid- Use Disorder please refer to "Outpatient Substance Abuse" and "Mental Health" sections in this EOC.

Access to Drugs That have a Restriction
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
- 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:

- 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;
- 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;
- 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's Health Management Level 1 Programs Department toll-free at 1 (866) 472-9483, Monday through Friday, 11:30 a.m. to 8:30 p.m. ET. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a 3-month supply of stop-smoking medication.

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

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.

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):

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

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

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

Prosthetic and Orthotic Devices
We do not cover most prosthetic and orthotic devices, but We do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section. We cover internally implanted devices and external devices 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

When We do cover a prosthetic and orthotic device, the coverage includes:

- fitting and adjustment of the device
- repair or replacement of the device (unless due to loss or misuse)
- services to determine whether You need a prosthetic or orthotic device

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

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

For internally implanted devices, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the Molina Health Care of Ohio, Inc. Schedule of Benefits to see the Cost Sharing applicable to these devices.

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines that are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to four brassieres required to hold a prosthesis per calendar year
- Podiatric devices (including footwear) to prevent or treat diabetes related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Contact lenses or glasses prescribed following intraocular lens implantation or prescribed for conditions caused by cataract surgery or injury ; a donor lens is not the first lens
- Intraocular lens implantation for the treatment of cataracts or aphakia

Durable Medical Equipment Cost Sharing will apply for external devices.

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

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Medical social services
- Home health aide services
- Medical supplies
- Medically Necessary medical appliances
- **Physical therapy –** Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to:
    - maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness;

- repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients);
- range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities;
- general exercise programs;
- diathermy, ultrasound and heat treatments for pulmonary conditions;
- diapulse; work hardening.

- **Speech therapy –** Treatment for the correction of a speech impairment.
- **Occupational therapy –** Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to:
  - supplies (looms, ceramic tiles, leather, utensils);
  - therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again;
  - general exercises to promote overall fitness and flexibility;
  - therapy to improve motivation; suction therapy for newborns (feeding machines);
  - soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation),
  - augmented soft tissue mobilization, myofascial;
  - adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation, and other types of similar equipment.
- **Cardiac rehabilitation –** Treatment to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, ongoing conditioning, and maintenance are not covered.
- **Pulmonary rehabilitation –** Treatment to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to outpatient short-term respiratory services for conditions expected to show significant improvement through short-term therapy.

Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a Covered Service.

The following home healthcare services are covered under Your product:

- Up to two hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist
- Up to four hours per visit by a home health aide
- Up to 100 visits per calendar year (counting all home health visits, except private duty nursing visits)

We also cover private duty nursing if such services are certified by Your PCP initially and every two weeks thereafter, or more frequently if required by Molina for Medical Necessity. There is a limit of 90 visits per calendar year for such private duty nursing services in the home.

You must have Prior Authorization for home healthcare services after the first 6 visits for outpatient and home settings. Services must be billed by a Home Healthcare Participating Provider agency.

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

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.

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.

Please Call Molina at 1 (888) 296-7677 if you need assistance with Medical transportation coverage.

Hearing Services

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

We do cover the following:

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

OTHER SERVICES

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

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina
- You or a Participating Provider notifies Molina before services are provided. (Prior Authorization is not required.)

Dialysis treatments of an acute or chronic kidney ailment may include the supportive use of an artificial kidney machine.

Please Note: Facility cost share applies please review your plans Schedule of Benefits. Professional services associated to covered dialysis services is at No Charge to You.

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
P.O. Box 22712
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.

You will not be entitled to reimbursement for charges for health care services or treatment that are not covered under this Agreement, specifically those identified in the "Services Provided Outside the United States (or Service Area)" in the "Exclusions" section of this Agreement.

EXCLUSIONS

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

Acupuncture
Acupuncture is not covered.

Artificial Insemination and Conception by Artificial Means
All services related to artificial insemination and conception by artificial means are not covered, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Bariatric Surgery
Bariatric surgery is not covered. This includes but is not limited to:

- Roux-en-Y (RNY)
- Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum)
- Gastroplasty (surgical procedures that decrease the size of the stomach)
- Gastric banding procedures.

Certain Exams and Services
The following are not covered. Physical exams and other services that 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. This exclusion does not apply to preventive services.

Cosmetic Services
Services 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
    - prostheses to replace all or part of an external facial body part

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

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

Dental and Orthodontic Services
Dental and orthodontic services, such as the following, are not covered:

- X-rays
- Appliances
- Implants
- Services provided by dentists or orthodontists
- Dental services following accidental injury to teeth
- Dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment

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

Dietician
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, underpads, 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
We do not cover drugs for erectile dysfunction unless required by state law.

Experimental or Investigational Services
Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition that We determine in Our sole discretion to be Experimental/Investigational is not covered.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigational if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy

of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigational based on the criteria above might still be deemed Experimental/Investigational by Us. In determining whether a Service is Experimental/Investigational, We will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service or drug on health outcomes;
- The evidence demonstrates the service or drug improves net health outcomes of the total population for whom the service or drug might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service or drug has been shown to be as beneficial for the total population for whom the service or drug might be proposed as any established alternatives; and
- The evidence demonstrates the service or drug has been shown to improve the net health outcomes of the total population for whom the service or drug might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Whether there is FDA approval for the use for which benefits are sought; or
- Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational.

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 "Claims Decisions, Internal Appeals, and External Review" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Gene Therapy
Most gene therapy is not covered. Molina covers limited gene therapy services 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.

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 Health Care," "Hospice Care," "Outpatient Substance Abuse Services" (residential recovery services), and "Mental Health Outpatient Intensive Psychiatric Treatment Programs" (crisis residential services) 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. For example:

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

Items and Services to Correct Refractive Defects of the Eye
Items and services such as eye surgery or contact lenses to reshape the eye to correct refractive defects 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.

Massage Therapy
Massage therapy is not covered.

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

Non-Emergent Services Obtained in an Emergency Room
Services provided within an emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

Oral Nutrition
Outpatient oral nutrition such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food are not covered, except as provided in this Agreement or as required by law.

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

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

Routine Foot Care Items and Services
Routine foot care items and services that are not Medically Necessary are not covered, 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 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 "Claims Decisions, Internal Appeals and External Review" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

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

Services Provided Outside the United States (or Service Area)
Any services and supplies provided to a Member outside the United States or outside the Service Area where the Member traveled to the location in order to receive medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialist care, and inpatient services are not covered when furnished outside the United States or anywhere else outside of the Service Area. This exclusion does not apply to Emergency Services provided to a Member while traveling.

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

Services Related to a Non-Covered Service
When a Service is not covered, all services related to that service are also 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 complication such as a serious infection, this exclusion would not apply and Molina would cover any services that We would otherwise cover as Medically Necessary to treat that complication.

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

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

THIRD PARTY LIABILITY

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

- Reimburse Molina for the reasonable cost of services paid by Molina to the extent permitted by Ohio law immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and,
- Fully cooperate with Molina in obtaining its lien rights for the reasonable value of services provided by Molina, to the extent permitted under Ohio 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.

If You recover less than the full value of damages, then Molina's claim shall be diminished in the same proportion as Your interest is diminished.

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 Agreement. 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.

Does Molina use Genetic Screening or Testing for the purposes of Renewal or changes in Premiums, Deductibles, Copayments and Covered Services?

No. Molina does not use genetic screening or testing, or the results thereof, with respect to cancellation, renewal, or limiting benefits or determining the Premiums, Deductibles, Copayments, Coinsurance or Benefits and Covered Services under Your Agreement.

Changes in Premiums, Deductibles, Copayments and Covered Services:

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

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

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

The termination date of Your coverage is the first day You are not covered with Molina (for example, if Your termination date is July 1, 2019, Your last minute of coverage was at 11:59 p.m. on June 30, 2019). 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.

You may request a review by the Superintendent of the Department of Insurance if You believe that this Agreement has been or will be improperly cancelled, rescinded or not renewed. You may contact the Department of Insurance at its toll-free number, 1 (800) 686-1526 or TDD number for the deaf or hard of hearing, toll-free, at 1 (614) 644-3745, or online at www.secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

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 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. At Our discretion, Molina may accommodate a request to end Your membership in fewer than 14 days.
- **Change Marketplace Health Plans**: You decide to change from Molina 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.

After Your first 24 months of coverage, Molina may not terminate Your coverage due to any non-fraudulent omissions, misrepresentations, or inaccuracies in Your application form.
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 which case Molina will provide You with written notice at least 180 days prior to the date the coverage will be discontinued.
- **Withdrawal of Product:** Molina withdraws Your product from the market, in which case Molina will provide You with written notice at least 90 days prior to the date the coverage will be discontinued.
- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina may terminate Your coverage as further described below.

Your coverage under certain Covered Services will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision Services covered under this Agreement and, as a result, such Member's coverage under those specific Covered Services will terminate as of 11:59 p.m. on the last day of the month that the Member turns age 19, without affecting the remainder of this Agreement.

Continuation of Coverage
In the event that Your coverage terminates while You are receiving care in a hospital, Molina will provide continuation of coverage until the earliest of the following:

- You are discharged from the hospital
- Your provider determines that inpatient care is no longer Medically Necessary
- The effective date upon which You become enrolled in any new coverage

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, Molina will send a notice of non-receipt of Premium payment and cancellation 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 nonpayment if We do not receive the required Premiums prior to the expiration of the grace period as described in the Late Notice.
    - The amount of Premiums due.
    - The specific date and time when 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 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 pend payment for Covered Services received during the 10-day grace period. You will be responsible for any unpaid Premiums You owe Molina 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 process payment for Covered Services received after the first month of the grace period so long as Your Premiums are paid in full before the end of the grace period. If We do not receive Premiums by the end of the 3-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. If You do not pay the full Premium payment by the end of the grace period, this Agreement will terminate. You will still be responsible for any unpaid Premiums You owe Molina for the grace period if You receive advance payment of the premium tax credit.

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

- On the last day of paid premium 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 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.

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Member?
The rights and responsibilities below are also on the Molina web site: MolinaMarketplace.com.

Your Rights
You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina.
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor (Your PCP) from Molina's list of Participating Providers.
- Be informed about Your health. If You have an illness, You have the right to hear about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina or Your care. You can call, fax, e-mail, or write to Molina's Customer Support Center.
- Appeal Molina's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina (leave the Molina 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 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 Molina did not meet Your linguistic needs
- Subject to eligibility requirements, Members may have the option to convert to the Subscriber under this Agreement under the following circumstances: 1) The Member's spouse dies, 2) the Member's marriage to his or her spouse is terminated by divorce, dissolution, annulment, or other legally recognized manner, or 3) the Member is a child that reaches the limiting age under this Agreement while he or she is still a dependent.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at **1 (888) 296-7677**.
- Give Your doctor, provider, or Molina information they need 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 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. Also, tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick

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

If You would like more information, please call Molina's Customer Support Center toll-free at 1 (888) 296-7677, Monday through Friday, between 7:00 a.m. and 7:00 p.m. ET.

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 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) 296-7677 for more information.

Your Healthcare Privacy
Your privacy is important to Us. We respect and protect Your privacy. Please read Our Notice of Privacy Practices, at the front of this Agreement.

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 to add it as a new 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" at the front of this Agreement 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 and Urgent Care Services, You ask for and get health care services from a doctor or hospital that is not a Participating Provider without getting Prior Authorization 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. Ohio State law requires Molina to put this statement into all of its contracts with providers.

Molina is not a member of any guaranty fund, so in the event of the insolvency of Molina, only Participating Providers are prevented from billing You directly for unpaid Covered Services that were rendered by the Participating Provider.

However, in the event of the insolvency of Molina, You may be financially responsible for services provided by non-Participating Providers, whether or not those services were authorized by Molina.

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

Molina Healthcare
PO Box 349020
Columbus, Ohio 43234-9020

If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to CVS:

CVS/Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

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 appeal by calling Molina toll-free at 1 (888) 296-7677. Call Monday through Friday, 7:00 a.m. to 7:00 p.m. ET.

How Does Molina 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 may 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) 296-7677. Call Monday through Friday, 7:00 a.m. to 7:00 p.m. ET. 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 a "Natural Death Act Declaration" are types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives.

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

For more information, call Molina's Customer Support Center toll-free at 1 (888) 296-7677. If You are deaf or hard of hearing, call Our dedicated TTY line toll-free at 1 (800) 750-0750. Or dial 711 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 insuring corporation 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; supplemental coverage as described in Ohio Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

- "**This Plan**" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.
- "**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual

agreement is prohibited from charging a Member is not an Allowable Expense.

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

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.

  However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
- The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

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

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

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of

situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

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

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

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

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

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

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

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

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

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

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

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

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

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state 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 Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

COMPLAINTS

What is a Complaint?
A complaint is any dissatisfaction that You have with Molina or any Participating Provider that is not related to the denial of healthcare services. For example, You may be dissatisfied with the hours of availability of Your doctor. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the Ohio Department of Insurance in the manner described in the Internal Appeals section below.

Molina recognizes the fact that you may not always be satisfied with the care and services provided by our contracted doctors, hospitals and other providers. We want to know about your concerns and any complaints you may have. We will respond to your complaint no later than 60 days from the date we received it.

You may contact Molina for assistance with filing your complaint over the phone, by mail or fax using the following contact information.

Appeals and Grievances Department	
Address:	Molina Healthcare of Ohio, Inc. Appeals and Grievance Department P.O. Box 349020 Columbus, Ohio 43234-9020
Phone:	(888) 296-7677, Monday – Friday 7:00 am – 7:00 pm EST
TTY:	(800) 750-0750 or 711
Website:	www.molinahealthcare.com

You may also contact the Ohio Department of Insurance

Ohio Department of Insurance Consumer Affairs	
Address:	Ohio Department of Insurance ATTN: Consumer Affairs 50 West Town St. Suite 300 Columbus, Ohio 43215
Phone:	(800) 686-1526
Phone:	(614) 644-2673
Fax:	(614) 644-3744
TTY:	(614) 644-3745
Website:	https://www.insurance.ohio.gov/Pages/default.aspx
File Online Consumer Complaint:	http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

CLAIMS DECISIONS, INTERNAL APPEALS, AND EXTERNAL REVIEW

Definitions

- For the purposes of this section, "Adverse Benefit Determination" means a decision by Molina to deny, reduce or terminate a requested health care service or payment in whole or in part, including all of the following:
  - A determination that the health care service does not meet Molina's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
  - A determination that a health care service is not a Covered Service;
  - The imposition of an exclusion source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including initial eligibility determinations;
- To rescind coverage on a health benefit plan.

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

"**Urgent care services**" means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

Appointing a Representative

If a Member would like someone to act on his/her behalf regarding a claim or an appeal of an Adverse Benefit Determination the Member may appoint an authorized representative. Members should send the representative's name, address, and telephone contact information to:

Appeals and Grievances Department	
Address:	Molina Healthcare of Ohio, Inc. Appeals and Grievance Department P.O. Box 349020 Columbus, Ohio 43234-9020
Telephone:	(888) 296-7677, Monday – Friday 7:00 am – 7:00 pm EST
TTY:	(800) 750-0750 or 711
Fax:	(866) 713-1891

You must pay the cost of anyone you hire to represent or help you.

CLAIMS DECISIONS

After a determination on a claim is made, We will notify You of a favorable determination or Adverse Benefit Determination within a reasonable time, as follows:

Request Types	Time Frame for Decision	Time Frame for Notification of Decision
Pre-Service Claim	Within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	Within forty-eight hours for urgent care services, or ten calendar days for any prior authorization request that is not for an urgent care service, of the time the request is received. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
Concurrent Service Claim	24 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	24 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
Post-Service Claim	30 days from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)	30 days from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)

Please Note: Additional information requests for Urgent Care Services will be made within 24 hours in accordance with state law.

If medical necessity is determined on appeal and a prior authorization is required for the benefit the determination will also include the authorization of the benefit in the determination.

Urgent Care Service Claim – A claim involving an Urgent Care Service is processed as timely as is possible given the circumstances and will always be processed within no more than 48 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.),or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations.

Initial Denial Notices
Notice of an Adverse Benefit Determination (including a partial claim denial) will be provided to You by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to Adverse Benefit Determinations involving an Urgent Care Service, notice may be provided to You orally within the time frames noted above. If oral notice is given, written notification must be provided no later than three days after oral notification.

An Adverse Benefit Determination notice will identify the claim involved, convey the specific reason for the Adverse Benefit Determination (including the denial code and its meaning), the specific product provisions upon which We base the determination, and the contact information for the Ohio Department of Insurance, which is available to assist You with the internal and external appeal processes. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal product rule, protocol, or similar criterion was relied upon to deny the claim. A copy of the rule, protocol, or similar criterion will be provided to You, free of charge. In addition to the information provided in the notice, You have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

The notice will describe Molina's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on review.

If an Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of the product to Your medical circumstances.

In the case of an Adverse Benefit Determination involving a claim for Urgent Care Service, the notice will provide a description of Molina's expedited review procedures, which We describe below.

INTERNAL APPEALS

You must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). You may appeal an Adverse Benefit Determination by means of written notice to Us, in person, orally, or by mail, postage prepaid.

Your request should include:

- The date of Your request.
- Your name (please print or type).
- The date of the service We denied.
- Your identification number, claim number, and provider name as shown on the explanation of health care benefits, which You will automatically receive when We process Your claim.)

You should keep a copy of the request for Your records because no part of it can be returned to You.

You may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service orally or in writing. In such case, all necessary information will be

transmitted between Molina and You by telephone, FAX, or other available similarly expeditious method, to the extent permitted by applicable law.

You may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time a request is made for an expedited internal appeal of an Adverse Benefit Determination if Your treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, if treated after the time frame of an expedited internal appeal (*i.e.*,72-hours). You may not file a request for expedited external review unless You also file an expedited internal appeal. Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by You relating to the claim.

On appeal, You may review relevant documents, request copies of any relevant information (which will be provided free of charge), and may submit issues and comments in writing. Upon request, You may also discover the identity of medical or vocational experts whose advice was obtained on behalf of Molina in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If We base the Adverse Benefit Determination in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, We will provide to You, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide You a reasonable opportunity to respond. However, if We receive the new or additional evidence so late that it would be impossible to provide it to You in time for You to have a reasonable opportunity to respond, the period for providing notice of Our appeal decision will be tolled until You have a reasonable opportunity to respond. After You respond, or have a reasonable opportunity to respond but fail to do so, We will notify You of Our decision as soon as reasonably possible, considering the medical circumstances.

Your coverage will remain in effect pending the outcome of Your internal appeal.

Time Periods for Decisions on Appeal

For appeals of Adverse Benefit Determinations, We will make decisions and provide notice of the decisions as follows:

TIME FRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIME FRAME FOR DECISION**
URGENT CARE SERVICE DECISIONS	WITHIN 48 HOURS from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
PRE-SERVICE DECISIONS	WITHIN 30 DAYS from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)
POST-SERVICE DECISIONS	WITHIN 30 DAYS from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.)

Urgent Care appeal or claims involving an Urgent Care Service is processed as timely as possible given the circumstances and will always be processed within no more than 48 hours from receipt of request. (If all information reasonably necessary and requested by Molina is not received in this timeframe this may result in a denial. Molina will inform you of the reason for denial.), or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations.

Appeals Denial Notices
Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided to You by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that We have denied a claim appeal will include:

- Sufficient information to identify the claim involved;
- The specific reason or reasons for the Final Adverse Benefit Determination, including the denial code and its meaning;
- Reference to the specific product provision upon which the determination is based;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;
- If We relied upon any internal Molina rule, protocol or similar criterion to deny the claim, then a copy of the rule, protocol or similar criterion will be provided to You, free of charge, along with a discussion of Our decision;
- A statement of Your right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing Molina to disclose protected health information pertinent to the external review; and
- If We base a Final Adverse Benefit Determination on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an

- explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to Your medical circumstances.
- Notice of voluntary alternative dispute resolution options, as applicable
- For assistance with appeals, complaints or the external review process You may write or call:

Ohio Department of Insurance
Attn: Consumer Affairs
50 West Town Street
Suite 300
Columbus, OH 43215-1067
Consumer Affairs: https://www.insurance.ohio.gov/Pages/default.aspxConsumer
Complaints: http://Insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx
Phone: 1 (614) 644-2673 or 1 (800) 686-1526 or
TDD: 1 (614) 644-3745
Fax: 1 (614) 644-3744

In addition to the information provided in the notice, You have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based.

EXTERNAL REVIEW

Understanding the External Review Process
After You receive a Final Adverse Benefit Determination or if You are otherwise permitted, as described above, You may request an external review if You believe that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service doesn't meet Molina's requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or is Experimental or Investigational.

Opportunity for External Review
An external review may be conducted by an Independent Review Organization (IRO) for Final Adverse Benefit Determinations involving Medical Necessity or medical judgment or by the Ohio Department of Insurance if the Final Adverse Benefit Determination involves a determination that the medical service is not covered by this Agreement. Molina will not choose or influence the IRO's reviewers.

Your coverage will remain in effect pending the outcome of the external review.

There are three types of IRO reviews: 1) standard external review, 2) expedited external review, and 3) external review of Experimental or Investigational treatment.

Standard External Review
A standard external review is normally completed within 30 days

Expedited External Review
An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 72 hours and can be requested if any of the following applies:

- Your treating physician certifies that the Adverse Benefit Determination or Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review

- The Adverse Benefit Determination or Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which You received Emergency Services, but have not yet been discharged from a facility

An expedited internal appeal is in process for an Adverse Benefit Determination of Experimental or Investigational treatment and Your treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated

External Review of Experimental and Investigational Treatment
Requests for standard or expedited external reviews that involve Adverse Benefit Determinations or Final Adverse Benefit Determinations that a treatment is Experimental or Investigational may proceed if Your treating physician certifies one of the following:

- Standard health care services have not been effective in improving Your condition,
- Standard health care services are not medically appropriate for You, or
- No available standard health care service covered by Molina is more beneficial than the requested health care service

Request for External Review in General

- You must request an external review within 180 days of the date of the notice of Adverse Benefit Determination or Final Adverse Benefit Determination issued by Molina.
- All requests must be in writing, except for a request for an expedited external review.
- Expedited external reviews may be requested electronically or orally.
- If the request is complete, Molina will initiate the external review and notify You in writing that the request is complete and eligible for external review.
    - The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information
    - The notice will inform You that, within 10 business days after receipt of the notice, You may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review
- Molina will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).
- If the request is not complete Molina will inform You in writing and specify what information is needed to make the request complete. If Molina determines that the Adverse Benefit Determination is not eligible for external review, Molina will notify You in writing, provide You with the reason for the denial, and inform You that the denial may be appealed to the Ohio Department of Insurance.
- The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Molina and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Molina and all applicable provisions of the law.
- Molina will pay the costs of the external review.

IRO Assignment

- The Ohio Department of Insurance maintains a secure web based system that is used to manage and monitor the external review process.

- When Molina initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio accredited IRO that is qualified to conduct the review based on the type of health care service.
- Molina and the IRO are automatically notified of the assignment.

IRO Review and Decision

- The IRO must forward, upon receipt, any additional information it receives from You to Molina. At any time, Molina may reconsider its Adverse Benefit Determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If Molina reverses the Adverse Benefit Determination, We will notify You, the assigned IRO and the Ohio Department of Insurance within one day of the decision. Upon receipt of the notice of reversal by Molina, the IRO will terminate the review.
- In addition to all documents and information considered by Molina in making the Adverse Benefit Determination, the IRO must consider things such as; Your medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under this Agreement and the most appropriate practice guidelines.
- The IRO will provide a written notice of its decision within 30 days of receipt by Molina of a request for a standard review or within 72 hours of receipt by Molina of a request for an expedited review. This notice will be sent to You, the Molina and the Ohio Department of Insurance and must include the following information.

    - A general description of the reason for the request for external review
    - The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review
    - The dates over which the external review was conducted
    - The date on which the independent review organization's decision was made
    - The rationale for its decision
    - References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

Binding Nature of External Review Decision

- An external review decision is binding on Molina except to the extent Molina has other remedies available under state law. The decision is also binding on You except to the extent that You have other remedies available under applicable state or federal law.
- You may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Molina

If You Have Questions About Your Rights or Need Assistance

You may contact:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://www.insurance.ohio.gov/Pages/default.aspx
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

DEPARTMENT OF INSURANCE EXTERNAL REVIEW

You may request an external review of a Final Adverse Benefit Determination by the Ohio Department of Insurance if You believe that a healthcare service has been improperly denied, modified, or delayed on the grounds that the healthcare service is not covered under this Agreement or You are denied an external review of an Adverse Benefit Determination or Final Adverse Benefit Determination. You may contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: External Review Unit
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

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 based on 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) 296-7677.

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 Ohio Department of Health by going online at www.donatelifeohio.org to add Your name to the registry.

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

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

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with Ohio 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 Program
Your Agreement includes access to a health activities program. The goal of the program is to encourage You to complete health activities that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activities we encourage you to complete, are described below. For more information, please contact Member Services phone number on your ID Card.

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

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

HEALTH 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 Management
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 also enroll in any of the programs above by calling the Molina Health Management Department at 1 (866) 891-2320 9:30 a.m. and 6:30 p.m. (MT), Monday through Friday.

Motherhood Matters®
A Prenatal Care Program for Pregnant Women

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

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

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

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

Your Baby's Good Health Begins When You Are Pregnant

You learn:

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

Other benefits include:

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

To find out more about the Motherhood Matters® program, call the Molina Health Management Department at 1 (866) 891-2320 between 11:30 a.m. and 8:30 p.m. ET, Monday through Friday.

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, Opioid education 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	Number to Call/ Contact Information
Molina 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 7:00 a.m. to 7:00 p.m. ET. When in doubt, call Us first.	**Customer Support Center** Toll-Free: **1 (888) 296-7677** TTY for the hearing-impaired: 1 (800) 750-0750 or dial 711 for the Telecommunications Relay Service
Health Management	To request information on programs for conditions such as asthma, diabetes, high blood pressure, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD)	**1 (866) 891-2320** between 11:30 and 8:30 p.m. ET, Monday through Friday
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	**1 (888) 275-8750** for Spanish: 1 (866) 648-3537
Motherhood Matters®	Molina offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	**1 (866) 891-2320** between 11:30 and 8:30 p.m. ET Monday through Friday
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that We have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	**(415) 437-8310** TDD: (415) 437-8311 FAX: (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 healthcare, but does not cover all medical expenses.	**1 (800) MEDICARE** **1 (800) 633-4227** TTY: 1 (877) 486-2048 www.Medicare.gov
Ohio Department of Insurance	The Ohio Department of Insurance is responsible for regulating health care services plans. If You have a grievance against Your health plan, You should first call Molina toll-free at 1(888) 296-7677, and use Molina's grievance process before contacting this department.	1 (800) 686-1526 **http://www.insurance.ohio.gov/ Consumer/OCS/Pages/ConsCompl.aspx** TDD: (614) 644-3745