2019
Molina Healthcare of Ohio, Inc. Agreement and Individual Evidence of Coverage

Molina Marketplace – Silver 150

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.

NOTICE: IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKA NATIVE. YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PRODUCT FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

MolinaMarketplace.com
Service Area: Counties of Ashtabula, Athens, Butler, Clark, Clermont, Coshocton, Cuyahoga, Fairfield, Franklin, Greene, Hamilton, Hancock, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Montgomery, Ross, Scioto, Stark, Trumbull, Wood

MOLINA® HEALTHCARE

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MOLINA HEALTHCARE OF OHIO, INC.
SCHEDULE OF BENEFITS

THIS PRODUCT INCLUDES ESSENTIAL HEALTH BENEFITS (INCLUDING PREVENTIVE SERVICES):

Your Covered Services include Essential Health Benefits as determined by the Affordable Care Act. Your Essential Health Benefits coverage includes at least the 10 categories of benefits as follows: ambulatory patient care; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services (including dental and vision care for Members under the age of 19). Please see the section titled "What Is Covered Under My Plan?" in this Agreement for a full description of Covered Services, including the Essential Health Benefits. Please note that pediatric dental services can be purchased separately through a stand-alone dental product that is certified by the Marketplace.

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

Deductible Type	**At Participating Providers, You Pay**
Medical Deductible	
Individual	$750
Entire Family of 2 or more Members]	$1,500
Annual Maximum Out-of-Pocket*	**At Participating Providers, You Pay**
Individual	$2,600
Entire Family of 2 or more Members	$5,200

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

Emergency and Urgent Care Services	**You Pay**	
Emergency Services	20%	Coinsurance per visit after deductible
Urgent Care Services	$20	Copayment per visit

Outpatient Professional Services**	At Participating Providers, You Pay	
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge	
Primary Care (PCP) and Other Practitioner Care	$10	Copayment per visit
Specialty Care	$30	Copayment per visit
Habilitative Services	$30	Copayment
Rehabilitative Services • Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Therapy – limit of 24 visits per therapy per calendar year • Cardiac Rehabilitation – limit of 36 visits per calendar year • Manipulation Therapy – limit of 12 visits per calendar year	$30	Copayment
Mental Health Services	$10	Copayment per visit
Substance Abuse Services	$10	Copayment per visit
Dental Services Related to Accidental Injury (limited to $3000 per episode)	20%	Coinsurance
Vision Services Related to Accidental Injury or Diseases Affecting the Eye	20%	Coinsurance

Pediatric Vision Services (Refer to PEDIATRIC VISION SERVICES section in the EOC for age limit)		
Vision Exam (Screening and exam, limited to 1 each calendar year)	No Charge	
Prescription Glasses		No Charge
Frames	• Limited to one pair of frames every 12 months • Limited to a selection of covered frames	
Lenses	Limited to one pair of prescription lenses every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • Scratch resistant coating, UV protection, and other options are listed in the Agreement section titled "Pediatric Vision Services."	No Charge
Prescription Contact Lenses		No Charge
In lieu of prescription glasses, limited to 1 pair of standard contact lenses every calendar year. Medically Necessary contact lenses for specified medical conditions require Prior Authorization		
Low Vision Optical Devices and Services (Subject to limitations; Prior Authorization applies)	No Charge	
Family Planning	No Charge	

** Please note, if You are seen in a hospital-based clinic, outpatient hospital Cost Sharing may apply.

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

Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Outpatient Surgery		
Professional	20%	Coinsurance after deductible
Facility	20%	Coinsurance after deductible
Infertility Services	20%	Coinsurance after deductible
Imaging (CT/PET Scans, MRIs) (Unless these services are performed while You are in an inpatient setting, Your Cost Share amount for these services will apply.)	20%	Coinsurance after deductible
Radiology Services (e.g., X-Rays)* **	$30	Copayment
Laboratory Tests* **	$30	Copayment
(Laboratory tests to screen for and determine onset of diabetes, including gestational diabetes)	No Charge	
Mental Health		
(Outpatient Intensive Psychiatric Treatment Programs)	20%	Coinsurance after deductible
Inpatient Hospital Services	**At Participating Providers, You Pay**	
Medical / Surgical		
Professional	20%	Coinsurance after deductible
Facility	20%	Coinsurance after deductible
Infertility Services	20%	Coinsurance after deductible
Maternity and Newborn Care (Professional and Facility services)	20%	Coinsurance after deductible
Mental Health (Inpatient Psychiatric Hospitalization)	20%	Coinsurance after deductible
Substance Abuse		
Inpatient Detoxification	20%	Coinsurance after deductible
Transitional Residential Recovery Services	20%	Coinsurance after deductible
Rehabilitation Services (60 day limit per calendar year)	20%	Coinsurance after deductible
Skilled Nursing Facility (90 day limit per calendar year)	20%	Coinsurance after deductible
Hospice Care	No Charge	

Prescription Drug Coverage*	At Participating Providers, You Pay	
Tier-1	$5	Copayment
Tier-2	$30	Copayment
Tier-3	30%	Coinsurance
Tier-4 (Maximum Cost Sharing of $100 per prescription fill for oral chemotherapy drugs)	30%	Coinsurance
Tier-5	No Charge	
Mail-Order Prescription Drugs	Up to a 90-day supply is offered at two times the 30- day prescription Cost Sharing.	

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

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

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment (All equipment and supplies other than for diabetes care)	20%	Coinsurance after deductible
Home Healthcare (Limit of 100 visits per year for all home health care visits, except private duty nursing visits) (Limit of 90 visits per year for private duty nursing visits in the home)	[No Charge] [after deductible] (Separate cost share may apply for other covered benefits delivered in the home setting (e.g., injectable drugs, durable medical equipment, etc.)	

Ancillary Services – Emergency Medical Transportation	You Pay	
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for both Participating Providers and Non-Participating Providers.)	20%	Coinsurance after deductible

Other Services	At Participating Providers, You Pay	
Dialysis Services	$30	Copayment
Diabetes Health Education Services	No Charge	

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

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

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

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

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

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

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

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

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

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

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

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
If you need help, call (800) 368-1019; TTY (800) 537-7697.

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اللغة العربية، فتتوافر لك خدمات المساعدة اللغوية المجانية. اتصل بخدمات الأعضاء. الرقم موجود على الجزء الخلفي من بطاقة هوية العضو الخاصة بك. (Arabic)

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

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

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

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

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات زبانی بدون هزینه در دسترس شما می‌باشد. با خدمات اعضا تماس بگیرید. شماره در پشت کارت شناسایی عضو شما درج شده است. (Farsi)

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

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

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

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